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"GOING NATIONAL"

IN her Biennial report for 1932-34, Miss Tucker said the N.O.P.H.N. had "gone National". Since that time, public health nursing has been brought increasingly into the national picture and hence the N.O.P.H.N. is increasingly active in representing to Federal and national bodies the aims, philosophy and standards of the whole public health nursing movement. In other words, the N.O.P.H.N. is acting as the national representative of its members both individual and corporate in the swift changes of our present day.

Ever since social security has been under discussion, the N.O.P.H.N. has been called into consultation by Federal agencies. Miss Tucker was the only nurse on the Advisory Committee on Health to the President's Committee on Economic Security. With the prospect—when Congress appropriates funds — of considerably expanded health programs under the Social Security Bill, the United States Public Health Service and the Children's Bureau are keeping in touch with the N.O.P.H.N. We have been consulted on questions of organization, supervision, program content, staff education and above all else *qualifications*. The excellent requirements being set by the Federal Civil Service Commission for public health nursing positions in the U.S.P.H.S., Children's Bureau and Health Department of the District of Columbia set a high example for the country as a whole. The Joint Vocational Service has given generous cooperation in supplying the records of candidates for these positions.

Then, there is much activity relating to public health nursing in the Works Progress Administration. Again the states and localities have been urged to set up local projects, which call for the most part only for unemployed nurses who are on relief. Again we have reiterated the "safeguards"* which will protect standards of service. As the states all know, a bulletin of the WPA was issued classifying nurses as "skilled labor". The N.O.P.H.N. joined forces with the American Nurses' Association and the National League of Nursing Education in getting the classification changed to "professional". We have verbal, and the promised written confirmation that this change has been made.

So much for a quick review of our efforts to keep public health nursing in the national picture. There have been many trips to Washington, many interviews in New York, long distance telephone conversations, telegrams and

*See PUBLIC HEALTH NURSING, March, 1934, p. 115.

dozens of letters not only to and from Washington but with puzzled states and localities all over the country.

At the same time that all this has been happening with the official groups in Washington, we have also been involved in many activities with the national private organizations. Space permits mention of only two important national events of this fall, "The Mobilization for Human Needs" under the auspices of Community Chests & Councils and the "Town Meeting" campaign of the National Health Council.*

The Mobilization for Human Needs got off to its Fall start by a most impressive conference in Washington on September 23-24, attended by some 300 delegates of national agencies and local community chest groups from all over the country. President Roosevelt in the opening speech gave strong endorsement to private initiative and urged local groups to increase their support of the many phases of private social and health work which are needed to supplement what public funds cannot and should not supply. Mrs. Roosevelt, as Chairman of the Women's Crusade, spoke charmingly and effectively of the need for private agencies and the necessity for raising private funds for their support.

"Mobilization" is now going on all over the country and the publicity loan folders, case stories, posters and statistics of the N.O.P.H.N. are in wide demand for speech-making, exhibits and campaigns all over the nation. We have been more closely identified with "Mobilization" this year than ever before through our loan of Miss Evelyn Davis for two months to Community Chests and Councils to act as Secretary of the National Women's Committee.

Last, but by no means least, we come to our newest effort—a plan under the ægis of our own National Health Council, of which the N.O.P.H.N. is an active member. For the first time, a nationwide Town Meeting campaign is under way to interpret health to the public under the slogan "Health Today and Tomorrow." We have helped in the planning of this nationally. One of our staff is on the "Steering Committee." We have contributed a tiny bit to it financially. We are constantly supplying facts, pictures, stories. All of our corporate agencies have been written to, urging their participation in their own local Town Meetings. The Town Crier is out, calling attention to health needs throughout the land and telling the world that sympathetic understanding and effective health service in American homes is very dependent on public health nursing. The N.O.P.H.N. hopes that local public health nursing groups everywhere are helping the Town Crier.

So it is that your National has tried to be a friend at court. If the signs of the times be true, there will be more need than ever this year for your National to represent you and the public health nursing movement *nationally*.

ALMA C. HAUPT.

STANDARDS OF PERSONNEL

We have had many favorable comments on Dr. Potter's article, "Our Responsibility for Better Government Personnel," which appeared in last month's magazine. Dr. Potter calls attention to our opportunity—indeed obligation—to secure a high quality of personnel for the positions that will be made possible through the Social Security Act. The Act under the heading of provisions of state laws states: (Title III, Section 303): "The Board shall make no certification for payment to any state unless it finds that the laws of such state . . . include provisions for (1) Such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are found by the Board to be reasonably calculated to insure full payment of unemployment compensation when due." (See also Title IV, V, etc.)

From this it would appear that our chief effort should be directed toward

*See PUBLIC HEALTH NURSING, September, 1935, p. 450.

state appointing authorities, to insure their recognition of the importance of the quality of personnel selected to carry on the activities authorized under the various provisions of the Social Security Act.

Since no stream rises higher than its source, the N.O.P.H.N. has always been deeply, one might say chiefly, concerned with the problem of qualified personnel. At least four committees (the Education Committee, the Committee on Personnel Practices in Official Organizations, the Committee (with A.P.H.A. representation) on Field Studies and Administrative Practice, and the Committee on Adjustments) are concerned with standards for appointment to positions. It is one thing however to study, discuss, recommend, and print qualifications, and another to get them applied locally. We believe the N.O.P.H.N. "Minimum Qualifications for Nursing Positions" do meet the practical problems. They have been tried, found wanting, revised, tried again, and are now accepted very generally by those with appointing power in many private and public agencies. However, they are not universally in force, not nearly well enough recognized by some of the newly inaugurated services or by some of the old-established agencies which think they have traditions to adhere to. Their application will come only through pressure brought to bear by the citizens of the towns and states. The public opinion of voters and taxpayers is still stronger than any other influence in politics and if an emotional appeal must be offered to start public opinion fermenting, what enzyme could be more potent than the thought: My health, the health of my child, even life itself may depend on the quality of nursing service provided by our Health Department.

"FINALLY, promotion of health presents a far more difficult administrative task than does prevention of disease, for the former calls for supervision of the whole population, twenty-four hours a day continuously, while the latter calls for supervision of but two per cent of the population, or less, at any one time; the former calls also for the minute control of immense numbers of everpresent demands, representing in sum total most of the forces of the universe; the latter calls for the minute control of a relatively very limited number of unusual demands, by no means constantly acting and some of them now very rare.

The solution at present seems to be to so educate every citizen concerning *everpresent* demands that each individual may act as his own health supervisor, and to leave in the hands of experts the study and control of those unusual demands which chiefly cause disease. Only those who devote themselves wholly to such demands can become sufficiently expert in their control to render real service.

If we may carry the last parable further—governments cannot undertake to directly navigate private ships. Nevertheless, governments can, should and do see that the private navigators themselves are educated in threading their several ways through the everyday winds and waves that they must encounter, and to look out for derelicts too. But the actual tracing and removal of derelicts from the high seas is impossible to the private navigator and obviously must remain a purely government responsibility."

—H. W. HILL, M.B., M.D., D.P.H.,
Bulletin, British Columbia Board of Health, August, 1935.

The Nurse's Opportunity to Teach Parents*

By WINIFRED RAND, R.N.
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THERE is nothing, I suppose, that is more freely given than advice. We give advice on how to trim a hat, how to bring up Johnny, what to have for dinner the night the Jones's come, what to take for a headache, what to use as a moth protector when putting away the winter clothes, etc. The advice is sometimes taken, sometimes, perhaps frequently, not, but we go right on giving it just the same. Advice is sometimes sought, sometimes not. Whether or not advice is taken is perhaps more dependent on two things than on any other. Was the advice sought and was it sought of a person whose judgment is trusted? If it was there is some likelihood that the advice given will effect action. If not, one's words of advice will doubtless waste their sweetness on the desert air but the steady stream of freely given advice will continue to flow.

Advice is a "how" or "what" matter rather than a "why" matter. How should a thing be done, what should be done? Perhaps it can be thought of as a short cut method to a certain type of action, a rule of thumb method of procedure. It implies perhaps a certain amount of thinking, and possibly even knowledge on the part of the advisor, it implies *influenced* (so the adviser hopes) action on the part of the advisee rather than a learning process.

It is important that we differentiate between this matter of giving and taking advice, and education. We must not fool ourselves into thinking that we are necessarily taking part in an educational program when we are only giving advice although it is perfectly possible to inject something of educational significance into the situation which is of an advisory nature, but to do so we must do something *more*—not just stop at advice.

Education implies an active process on the part of the student, an emphasis in the interpretation of the word for which we owe thanks to the Progressive Education Movement. Schools are child centered rather than teacher centered as they have tended to be in the past. The teacher is not filling the empty bottle of the child's mind with knowledge, the teacher is guiding and assisting the child as he himself acquires knowledge. The advisor, if he is to inject something of educational value into the advisory situation, is not just telling a person what to do or even how to do it; he is helping and assisting the advisee to see why this or that should be done in this or that way, to understand the fundamental meanings, to get beyond the particular as expressed in a given situation to something which has in it the element of universality.

DIFFERENCE BETWEEN ADVISING AND EDUCATING

It is easy for the nurse to give advice; it is much less easy for the nurse to teach. "You ought to bring your baby to the clinic, Mrs. Brown, to see the doctor." Quickly said, often *not* acted upon, perhaps many times acted upon because a personal relationship, valuable in many ways, has been established between the nurse and Mrs. Brown. Mrs. Brown brings the baby to the clinic because she likes the nurse and wants to please her, although she may not continue to do it when the nurse moves to another district. But is that education? No, that in itself is not education although it may be a first step, for education may result from the experience of the clinic and later contacts. Much less easy, more time consuming even, is it to give uneducated Mrs. Brown some understanding of

*Presented at the Institute on Maternity and Child Health, New York Hospital (N. Y.), June 14, 1935, held under the auspices of the Maternity Center Association and the N.O.P.H.N.

what the clinic may mean for her and her baby. There must be the marshalling together of facts which the nurse has and which perhaps are only available to Mrs. Brown through the nurse, and the presenting of them in such a way that Mrs. Brown understands them and realizes that they apply to her and her baby, that they are of real significance to *her*. Conviction which leads to action is not just an intellectual process. There is something of an emotional coloring, a feeling tone which is a necessary part of the process and must not be ignored. One can intellectually agree to the reasons why adequate rest is important but one will not take adequate rest until one *feels* one needs it, until the intellectual process has taken on that emotional coloring which means a result in action.

In a certain specific field, originally that of caring for the sick, nurses have been equipped for a good many years to give advice on nursing the sick (don't let any one misunderstand me and think I refer to treatment). The field has widened as the years have passed and the nurse has given advice in health matters. She has been looked upon as something of an authority in her field and she has been one of whom advice has actually been sought and, I am sure, many times taken.

Has she, especially as she has gone out into the field of public health, relied on advice-giving which has not always been sought, instead of becoming an educator? It is such an easy pitfall into which to fall and I believe that we have frequently fallen into it. We are recognizing that this is true, we are making many valiant efforts to climb out but we are not entirely out. We need changes in our professional education if we are to avoid these pitfalls in the future. We want to really become educators, not simply advisers, although we undoubtedly need to continue with the function of advising, using it as a tool in our teaching. So *much* advising is a waste of effort. Assisting in an educational process is not.

THE NURSE IN A SPECIALIZED FIELD

Although we look upon living as an educational experience in itself we still count on acquiring knowledge in specific fields through actual instruction in those fields. We take a course in chemistry, a course in French, a course in history. The teacher of chemistry is a specialist in that field, the teacher of French has a knowledge of French, the teacher in history has devoted much of his time to the study of history; that is, each one has acquired special skills in an individual field and thereby has something of fundamental necessity to the teaching of that subject. The nurse today is expected to be one of the specialists in the field of health and it is no small task which she is expected to perform. Consider for a moment how tremendously her field has widened; first she was one who cared for the sick, then she was recognized as one who should be concerned with the positive consideration of health, but the emphasis was on physical health. We studied how to prevent infant deaths, then we tried to keep well babies well and lastly we have come to interpret health as a *whole* state of being, involving all of man, not merely his physical body. We are learning more and more of the intimate relationship between the physical, the mental, and the emotional life of the individual. The nurse must, therefore, in giving consideration to health give heed to the whole individual. You have heard this said before and it does not need elaboration here but simply restatement as a definition of the field in which the nurse is to serve as an educator. She has not sloughed off her responsibility for nursing the sick. She has added on the responsibility for educating in health, although she may choose different paths for her intensive work, in hospital, in private duty, or in public health.

THE OPPORTUNITY WITH PARENTS

Wherever we work, however, I venture to say that a goodly proportion of our work brings us into direct contact with parents. Q.E.D. (to borrow from the field of geometry), we find ourselves inevitably in a strategic position to take some part in parent education. There we are—what are we going to do about

it? It is a little discouraging sometimes to see what we do do about it. A few weeks ago a parent who had also been a nurse, although she had dropped out of professional activity and had gone into the field of parent education after some years of family life, came to my office in a good bit of distress at some of the advice which she knew of nurses giving to parents about the care of their children and wanting to know if something couldn't be done about it. I was glad to be able to tell her that something really was being done about it, that there was an awakening in the profession to the need of equipping nurses with a knowledge of children and child development which they needed in order to serve adequately in this field in which they found themselves. As she had a connection with one hospital where she felt teaching along this line was hopelessly inadequate, I suggested that she herself might do something, might indeed go to the superintendent of nurses, talk the matter over and possibly offer her services for some classes which might open the nurses' eyes to the needs of the whole child.

If, for example, we could stop every nurse in the country tomorrow from saying to a mother who complains that her child will not eat carrots, "You must make him eat them," and could change that kind of advice into an understanding conference with the mother on how we may develop within the child a coöperative attitude toward some of the disciplines of life or help the child in his learning to eat and even like new foods, we would have made a very real contribution to the parent education movement. If each and every nurse in conferring with mothers about the feeding of their children, for example, could give them an understanding of the fundamental principles which guide us in helping develop desirable attitudes in children, they might also be able to give them a helpful insight into some of their own difficulties, for understanding children leads frequently to an understanding of people, even possibly our own selves. If each and every nurse could help mothers to an understanding of the principles involved in toilet training, could help them to appreciate that it is a learning process, that learning is not accomplished immediately, that if by our treatment of the child we develop antagonisms or fears toward this particular learning process, as we frequently do, we may prolong the learning unduly and let ourselves in for a long period of bed wetting and its usually attendant annoyance! If each and every nurse could do that much in the field of parent education, the wet beds of this country, I would almost venture to say, could be cut in half.

If each and every nurse could convince all the mothers with whom she comes in contact that children need to grow toward emotional as well as physical maturity, that in order to do this they must be freed to grow and not kept emotionally tied to their mothers, that "keeping him a baby as long as you can because he is only a baby once" is a hideous bit of advice based on selfishness, they would be doing another bit in the field of parent education.

MISGUIDED EMOTIONS

There is no doubt that when one gets into the field of the emotions there may be many a parent who is herself emotionally maladjusted due doubtless to a faulty sort of life experience which has affected her education and there may be many mistakes made by her in her treatment of her own children because of her own maladjustment. The nurse is not equipped to make a diagnosis as to causes underlying the woman's condition, but if she is sound in the educational material which she gives the woman and can give some help in carrying out procedure, the woman should not be worse off for having learned a few techniques, the child may be saved from a certain amount of unfortunate treatment and the woman herself may possibly profit somewhat. For example, there may be a woman who is unconsciously trying ~~to~~ keep her child attached to her. Without the nurse's teaching she might have nursed the child overlong; with the nurse's teaching she may be convinced of the importance of weaning. True, she may develop some other method to keep the child attached

to her, as, for example, frequently considering her too sick to go to school, but the nurse may again effect some release for the child by the very fact of her knowledge of physical conditions. There are without doubt many situations where the underlyling cause of the deplorable treatment of children is due to a fundamental personality problem which calls for therapeutic treatment, but this is not by any manner of means the whole story nor is it the part of the story which belongs to education. It calls primarily for treatment and it is only to be hoped that treatment can be secured. Certainly it is the nurse's responsibility to get treatment for the woman if she possibly can.

RESULTS OF IGNORANCE

But much unfortunate treatment of children is due to ignorance. There really are people who are fairly adequate and even intelligent people who have thought that to be an adequate parent meant a long period of waiting on children hand and foot, who thought having the tiny child help to undress himself was too hard for him, that the adult was thoughtless and unkind who did not immediately jump to help a child who was struggling with something. They have thought the adult actually cruel who did not jump to cover the child with kisses when he bumped his head and that the thing to do to comfort the child was to call the floor naughty for bumping him. There are still many people dealing with children who think that love of children will be expressed by constantly amusing them or attaching the children to themselves instead of realizing that the greatest love is shown when one can honestly give the child freedom for growth, respecting him as an individual who is seeking to live as an independent, thought, social being as soon as he is able. The adult's part of the child's life is to promote that growth as intelligently and wisely as he can. The child is not with the adult primarily to give that adult satisfaction.

There is still much ignorance on the part of the public about children. I wish it might be said that no nurses belonged to the group of people who are ignorant about children, for I think it very important that they should be wise and equipped with the necessary knowledge since they are in such a strategic position to give parents some understanding of the child. But we cannot say that today. There are nurses who do not know and yet they are inevitably being called upon, at least, for advice. It behooves us, therefore, to work intensely for two things—for education in these matters for all those who are preparing to be nurses, and for further education of those nurses who have missed this part of their education.

Surely nurses can have enough understanding of child nature to prevent at least "the grosser faults of child care" as Dr. Gesell has called them, and obviously there are still a great many "grosser faults" committed.

THE NURSE'S RARE OPPORTUNITY

There are various ways in which the nurse can take part in the parent education movement. Probably she is most valuable as the individual instructor, starting with the individual's specific situation and helping her to discover principles and then put them in practice. I see the public health nurse doing this type of thing in every home to which she goes where there are parents and children. I see great possibilities in the child health clinic, a possibility demonstrated some years ago in Dr. Thom's habit clinics in Boston. A nurse with additional training in child development and parent education could, I am convinced, give much individual instruction but could use the clinic as well as the home for this instruction. I use instruction instead of advice because, although advice will almost inevitably be given, it is the teaching and learning possibilities in the situation which I want to stress. The clinic, as we all know, can be used for group instruction as well, and group instruction, if it can be followed by the individual contact, as it can when part of a public health nursing project, is, I believe, especially valuable. Thus one has the chance of discovering whether or not the learning has been sound and whether or not the parent has been able to translate prin-

ciples into action, for after all the purpose of parent education is to affect the functioning of parents as parents. There are certain dangers in group instruction especially if one is dealing with a group who have not progressed far in their education. Even in the more privileged groups one comes across this danger. For example, a few years ago I remember a study group in which we found that some of the members had misinterpreted some of the things said in regard to sex education and therefore were in a worse state than if they had not gone to the study group. Then, too, one sometimes hears what one wants to hear in the hope of backing up one's own procedure. For this, as well as for other reasons, one is convinced of the value of both fathers and mothers attending study groups. For the sake of consistency and harmony it is important that both father and mother be educated and there is doubtless more probability of correcting mistaken hearing if two people in the same family hear what is said and what is advised.

There are various methods used in parent education: the lecture, the group, individual instruction, the printed page, the radio, the movie. Witness the increase in books on child care and also the entrance of the radio into the field of education. No one method has been proved, I believe, the best. We probably need to use them all, but the nurse I see as one having a unique opportunity for individual instruction. Is there any other one group in this country that has such access to homes and the family situation? I doubt it—even the insurance agent probably does not go into so many homes. The nurse not only has access to homes but she is also welcomed there. She has, on the whole, a group receptive to her teaching. Think what her opportunity is! Think what she might do in the way of reducing wet beds! But all joking aside, think what she might really do in the way of giving parents that knowledge of human needs which would result in an understanding of personality and therefore a wiser guidance of its growth.

A Father Speaks

Editorial Note: The Father speaks so well in the August, 1935, number of *Mother and Child* (London, England) that we are quoting at some length from his remarks. This father is vice-chairman of the Central Union of Fathers' Councils in England.

SO far as I am aware, this is the first occasion on which a representative lay father has had the privilege of addressing a health conference of this nature, and while I realize that I have not the time, nor is this the place, in which to outline even briefly the introduction of the Fathers' Committee movement, I feel that I should preface my remarks on my subject by a few comments on the place of the father in the home and in the infant welfare movement.

I think there is little doubt that the modern father is more in touch with his children than was his Victorian predecessor, who at home was "He who must be obeyed," "He who must not be disturbed," but all too rarely the one to whom the children looked for understanding and affection.

This paternal change of heart took place, I believe, when the medical profession generally still regarded fathers as being unfortunately necessary, biologically, to the continuance of the race, but, that apart, of very little interest in the scheme of things medical . . . .

This idyllic state of affairs did not, however, last for long. Murmurs began to reach centers of a sinister being in the background who negatives the doctor's advice and prescription on the ground that "he didn't hold" with pregnant mothers being "messed about" and having their "teeth done"; who objected to remedial treatment for his offspring because they would "grow out of" their childish disabilities. And so, in many infant welfare clinics, the father became bracketed with that other arch-obstructionist, grandma, who because she had

"buried twelve" felt entitled to be regarded as an authority on child rearing.

The reaction of infant welfare centers to this menace varied, and still varies; in many the father is still regarded as a stumbling block in the path of progress, in others as a necessary evil, while yet a third group have taken the trouble to meet their fathers, talk to them, organize them and enlist their coöperation. Hence the formation of Fathers' Committees, the foundation of the Central Union of Fathers' Councils, and my presence at this Conference.

One rather interesting discovery was made by those who cultivated their fathers, and that was that in 90 per cent of cases the father as an obstructionist was a myth, a creature evolved of the mother's imagination as a barrier behind which she and her child could hide and avoid a trifling amount of trouble and, maybe, momentary pain. . . .

Fathers are not trained to become babies' nurses, mothers' aids, or charwomen's substitutes, but by means of regular lectures they are made aware of that standard of cleanliness and hygiene, both of the person and the home, which is necessary to good health, and they can ensure that, in their own homes at least, that standard is reached. They can and do insist on the regular attendance at the clinics of their wives and families, and, even more important, that the treatment advised there is carried out. In one respect, I am informed by competent authorities, the interested father is a better safety-valve for the family health than the mother, inasmuch as he is often more apprehensive regarding minor ailments. Well, that is all to the good. Minor ailments well treated rarely lead to major misfortunes, and any doctor would sooner suggest the use of a handkerchief as a first-aid treatment for stuffy breathing than prescribe for pneumonia.

So far we have regarded the father in his own home, but fathers meet other fathers and prospective fathers at business, at sport, in their clubs, and are able to establish with them a personal contact that is outside the range of any medical officer or health visitor. It follows, I think, that if the fathers at all the centers are convinced—and how easy it is to convince them—that the health of their own families is due to the preventive treatment given at the centers, then they will form your most effective missionaries and propagandists.

The subject of this debate is the cultivation of public opinion on matters concerning the health of children from two to five years of age, and I would submit that, in many cases, those who should guide public opinion are themselves most in need of guidance. Municipal authorities, for instance, are too often lax in matters of house sanitation and drainage, provision of milk and medical services and comforts, slum clearance and street cleansing, all of which affect the health of the small child. In such cases a well instructed and keen Fathers' Council can be of inestimable value as a spur either by direct representation to the laggards or through the media of election propaganda and the ballot box.

From time immemorial the father has been the protector of his family. No mastodons, dragons or mammoths now threaten the tribe, but they are still menaced by ignorance, ill health and disease, and we fathers still claim our ancient privilege to take our place in the forefront of the battle against these enemies.

The only weapon against these foes is knowledge. We look to you to arm us with this weapon in order that we, in turn, may arm our families and all with whom we come in contact, so that we may take our part in the fight to give each child as its birthright the inheritance of health.

Consumer-Protection in Cosmetics and Drugs

By MARGENE O. FADDIS
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AS long ago as 1759 the wise Dr. Samuel Johnson was commenting on the "magnificence of promises" of advertisements and of their playing upon the passions of the people. One wonders what Dr. Johnson would say if he could return to the civilization of 1935. What would he think of our business of advertising? What would be his reaction should he turn a radio dial at the moment in which the beautiful voice of a well known beauty specialist is casting its evening spell? Or what would have been his comments could he have listened to the hearings of the Pure Food and Drugs Act revision in the second session of the Congress of the United States in the year 1934?

Patent medicines and all their ilk were in their infancy during this period of advertising of which Dr. Johnson wrote. The first medicine known to be patented was a consumption cure known as "Tuscarora Rice"[1] in 1711. Since that time the manufacture, sale, and advertising of such substances—augmented tremendously of course by the use of cosmetics—have assumed almost unbelievable proportions. Very interesting figures which reveal the growth of output and the increase of advertising of patent and proprietary medicines, dentifrices, *et cetera,* may be found on pages 874 and 899 of the *Recent Social Trends* of the President's Research Committee. On studying these one begins to comprehend how truly important the question of advertising has come to be. Popular magazines, newspapers, and radio stations have become dependent upon advertising for no small proportion of their income. The corner drug store's sale of patent and proprietary drugs is usually a far more important source of income than that which is derived from the compounding of prescriptions. This offers explanation of the fact that the fate of all the bills which have thus far been introduced into Congress for the protection of the consumer in his purchase of food and drugs has been largely determined by the powerful lobby which represents these groups.

According to the survey of the Committee on the Costs of Medical Care,[2] Americans spend a total of $715,000,000 per year for drugs. This amount includes those bought on the prescriptions of private physicians and hospitals, but the larger sum—$525,000,000—is that spent by people who buy medicines on their own initiative. Part of this goes for what might be termed legitimate "home remedies" but approximately half of the total figure, *i. e.*, $360,000,000, is spent for so-called "patent medicines." What a boon even a very small portion of that would be if it could be diverted into various programs for the improvement of the people's health. Even the sum spent for advertising of drugs alone would give a new stimulus to the public health workers of our nation. The above committee estimates the annual advertising bill of the drug industry as $70,000,000![2]

Obviously, such a situation has great economic and social significance. Even if financial outlay were the only point of consideration, social waste would be exceedingly large. Yet it is impossible for anyone to escape the various media of advertising for now that the radio is universally in evidence, even the blind are subjected to the wiles of the advertiser. The confused babel which James Rorty gives on page 70 of his interesting book on advertising, *Our Master's Voice,* which is a meaningless conglomeration of the slogans of numerous concerns, is not much worse, actually, than some of

[1] *Four Thousand Years of Pharmacy,* p. 412 (see bibliography on page 580)
[2] *The Costs of Medicines,* pp. 18 and 153.

the broadcasting of which we have been made victims. Truly we are in a dilemma. And if the course of the attempts at revising the Pure Food and Drug act is indicative, the way out is still a long way from being found.

EARLY FOOD AND DRUG LEGISLATION

The *Congressional Digest*[3] of March, 1934, gives a summary of legislation which has been undertaken in the past. The initial step was taken in 1850 and concerned certain restrictions on tea. The first event in the history of the control of drugs occurred the following year when members of the College of Pharmacy met in New York to consider the existing laws which controlled the importation of "adulterated and sophisticated drugs." This proved to be important for out of the meeting came the American Pharmaceutical Association. In 1884 there was introduced into the House a resolution which authorized the investigation of adulterated food and drugs by a committee on public health. It received fourteen favorable votes! Other legislation occurred following this but of primary importance within the next several years was the message of President Roosevelt to Congress in 1905 which called for enactments on the misbranding and adulteration of food, drugs, and drinks. Finally on January 1, 1907, the Pure Food and Drugs Act of 1906 went into effect. These were important years for in 1905, also, the Council on Pharmacy and Chemistry of the American Medical Association came into being with a plan for the investigation of proprietary medicines. A later outgrowth was the Bureau of Investigation.

POPULAR PROPAGANDA OF THE YEARS 1905-1907

A search through the periodicals of the years 1905 to 1907 reveals interesting things. Much of the material has a strangely familiar sound; some, as we can now see, was too optimistic; a little indicates that in these intervening years something really has been accomplished; nearly all of it, as now, reveals the dilemma in which the people who were interested in the subject found themselves. *The Nation* of November 9, 1905, rings a note of optimism but tells also of the cancellation of advertising contracts between publishers and drug manufacturers when detrimental material was published in the paper which carried the advertising. It reports, too, a resolution of an Ohio newspaper publishers' association to adopt the policy of printing the attending physicians' names in every death notice if a certain hostile bill should be passed. The March, 1905, *Ladies' Home Journal*, in an article written by Edward Bok, who was a very potent influence in this early crusade, points out the reasons why secret formulæ are contrary to medical ethics and the differences between the physician with his long period of preparation and the quack who prescribes not only without education and training but without even seeing the patient. Mr. Bok also wrote of the use of alcohol, morphine sulphate and cocaine, and in a later issue (February, 1907), Harvey W. Wiley wrote of the dangers of headache powders. Especially were pointed out those of acetanilid, caffeine, and phenacetin. The patent had recently expired for this latter and there was anticipated a great rush of the patent medicine interests in taking advantage of this fact. *The Outlook* for April 7, 1906, relates the story of giving away dangerous drugs in order to cultivate a taste for them—so-called catarrh cures which contained cocaine. The same magazine for June 2, 1906, tells of the National Conference of Charities and Corrections in which there was a discussion on patent medicines and poverty. It was said at this time that in many places nine-tenths of the money invested in them came from the very poor and that in one city cocaine was sold to the amount of $5,000 a week to this group. The *North American* of April 19, 1907, speaks of the fact that the Department of Agriculture would soon be ready to begin court action against those who violate the act of 1906 and adds the prognostication that

[3] *Congressional Digest*, p. 66.

very few actions would be necessary. (One wonders if this author still lives and has read any of the Notices of Judgment of the Department of Agriculture.) These, and many other examples which might be given, serve to show the points of emphasis of these early days—those which have a familiar ring and those whose tone is different because of the helpful results of the Act of 1906.

WHY "PATENT MEDICINES" ARE NOT REALLY PATENTED

Actually, the term "patent medicine" is a misnomer.[4] There are only a few of the legion which are so-called which are really that. In order to obtain a patent there must be proof that the article is "new and useful" and it is nearly always impossible to find such proof in these cases. Furthermore, the composition must be made known. One might think that in this day of chemical laboratories, where analyses can in most instances be easily made, such a provision would not be so important in the case of patent medicines. However, such is not the case for secrecy is the foundation upon which their success is built. The mystery of the cough medicine or the headache remedy which the poor man buys at the corner drug store is highly important. Finally, the patent is good for only seventeen years and at the end of that time becomes public property. Certainly no one whose product has the successful sales that a certain popular headache remedy has, for example, wishes to relinquish the resulting income after so short a time. Instead, therefore, he applies for a trademark and by means of a well-timed and planned advertising program heralds the virtues of his product far and wide. If he is clever, and if his conscience is not very alert, his fortune is practically assured for it is easy to instill the wonders of this substance in the minds of the people through the medium of the product's name, and although the trademark is good for only twenty-one years, it can be perpetually renewed.

THE PURE FOOD AND DRUGS ACT OF 1906

In 1906, after a long and difficult battle, the Pure Food and Drugs Act was finally passed. Edward Bok, the editor of the *Ladies' Home Journal*, *Colliers' Weekly*, Dr. Harvey W. Wiley, and others were largely instrumental in the passage of the measure. The bill, as its name implies, concerns both food and drugs but this discussion will be confined to the part applying to drugs.

To begin with, the law, being federal,[5] is effective only when interstate commerce is involved. It prohibits "false or misleading" statements, on or in the trade package regarding composition or origin; it prohibits, through the Sherley amendment of 1912, "false and fraudulent" statements regarding curative effects; it requires the label to declare the presence and amount of eleven drugs and their derivatives: alcohol, morphine, opium, cocaine, heroin, alpha eucaine, beta eucaine, chloroform, cannabis indica, chloral hydrate, and acetanilid.

There is a difference between that which constitutes violation of the law concerning the claims for composition and for curative effect. In the case of the latter, they must be both *false* and *fraudulent*. In order to convict, there must be proof of a deliberate attempt to defraud. Also, there is an important point in the phrase, "on or in the trade package." Few people read labels properly and even those who do are far more impressed by what they see in their newspapers or magazines or on the billboards and by that which they hear on the radio. More and more important, too, have become the restrictions concerning the eleven drugs. There have been added to these, through the great advance in synthetic drug manufacture, a veritable legion of new ones which were undreamed of in 1906 but which may be equally as dangerous as some of the original eleven.

HOW THE LAW MAY INTERFERE

In 1819 a woman whose name is now famous as an advisor in female ills was

[4] *Chemistry in Medicine*, pp. 395-416.

[5] *Patent Medicines, the Nostrum, and the Public Health*, pp. 5-10.

born in Massachusetts. Quite by chance[6] the formula for "Women's Weakness" fell into her hands. A Lynn machinist who was unable to pay her husband a debt in the 1860's gave him the recipe as partial payment. His wife, Lydia, added more and more ingredients until her concoction came to have quite a local reputation and "women's weakness" began to decrease. The evolution of this famous compound illustrates many points. At first the goal was to sell one bottle daily. Later sixty dollars was paid for a column on the first page of the Boston *Herald* and within two days three gross were ordered. Next a son conceived the idea that since so many people had, or thought they had, kidney difficulties, the pamphlets should make some reference to these maladies. In 1879 the supposed inventor's picture was made a part of the advertisement. It was indeed a successful innovation. Unfortunately, the law of 1906 made some restrictions in the labels (see pages 400 and 401 in *Chemistry in Medicine* for illustrations), but the lady's vegetable compound has become increasingly well established. All this in spite of the fact that in 1905 the *Ladies' Home Journal* and *Colliers* joined in an attempt at exposure. They concentrated on a picture of Lydia's tombstone—a proof that she was no longer able to give advice. But, whatever the reason, earnest testimonials have continued to pour in and the sale has gone merrily on its way.

THE CHAMBER OF HORRORS

In the spring of 1934, the writer visited the Tugwell exhibit in the Department of Agriculture in Washington. This display, called by some "The Chamber of Horrors," illustrated two things. First, the fact that the law of 1906 has been productive of some good as indicated by row upon row of bottles, the contents of which have in some way or other violated the provisions of the law. There were the soothing syrups which contained paregoric which many mothers gave their babies, little realizing they were administering a form of opium. Lingering by the first group one might think that after all the law *has* accomplished something and for the moment might forget its shortcomings. That, however, could not be for long, because the remaining sections were dramatic reminders that the world in which we live today is a very different sort of world and that new measures are necessary for consumer-protection.

It is difficult to say which of the exhibits was the most striking. There were several on food revealing, for example, the false bottoms in cheese boxes, which are very deceptive as to the quantity of cheese, and plain, eggless noodles wrapped in yellow cellophane—correctly labelled "plain noodles" to be sure, but so inconspicuously that the yellow cellophane was much more important. More arresting by far, however, were the exhibits on drugs and cosmetics. There was the diabetic cure which was made from horsetail weed and sold for twelve dollars a pint. The display included the testimonials which had obviously been written in all good faith, but opposite them were photostatic copies of the death certificates of the writers—people who had died from diabetes mellitus. In the lawsuit which followed the Food and Drug Administration's attempt to control this sale, Doctor Eliot P. Joslin of Harvard, who is, of course, one of the foremost authorities on this disease, testified. The government lost its suit because although they proved that the claims which the manufacturer had made were "false", they failed to show that they were "fraudulent". It is indeed difficult to prove that an individual plans deliberately to defraud! There were two striking groups of pictures of the use of a "lure for eyelashes" which resulted in blindness, and of a depilatory cream which had succeeded in removing the superfluous hair as guaranteed, but had gone considerably beyond that point and removed all but a few straggling

[6] *American Mercury*, 22: 172-9.

locks in the crown of a woman's head. Thallium acetate is a certain depilatory but in the hands of the unscrupulous, it is indeed a cure attended with unlimited risks.

Some have said that the Chamber of Horrors exaggerates, though probably that would scarcely seem to be true to the victims represented. Certainly it points out that the time has long since come when the Pure Food and Drugs Act of 1906 is as outmoded as the covered wagons which carried American pioneers across the country.

(To be continued).

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YOUR BEST FRIEND CAN NOW TELL YOU!

IN *Science News Letter* for June we read that a remedy for offensive breath odors seems at hand. To quote Drs. Howard W. Haggard and Leon H. Greenberg, of Yale University from an article in the *Journal of the American Medical Association:*

"The breath can be immediately and completely rid of the odor (garlic) by washing the teeth and tongue and rinsing the mouth with a solution of chloramine . . . which reacts chemically with the essential oils and deodorizes them." The solution of chloramine was made by dissolving one 4.6 grain tablet in a small amount of water. Chloramine is a well known chemical available at drugstores which is used in the treatment of wounds and for sterilizing drinking water. In the Yale treatment the tongue was brushed, for the papillæ at the base seem to be the source of odor from retained food particles.

In their experiments Drs. Haggard and Greenberg first proved that the source of most obnoxious breath is not systemic but local. It arises, at least in the case of onions and garlic, solely from particles retained in and about the structures of the mouth. Air in the lungs does not taint the blood; the stomach is not at fault, nor is the saliva.

The physicians set about either to remove or deodorize the particles. They brushed the teeth and tongues of their subjects with soap and water and rinsed their mouths. Still the odor remained. Next they tried the proprietary mouth washes which rely on alcohol to sweeten the breath. These only masked the odor for from fifteen to twenty minutes. Finally they hit upon the chloramine solution treatment, which brings lasting relief when used with thorough brushing.

Lay Participation in Social Planning*

By RUTH HYDE HARVIE
Secretary, Association of the Junior Leagues of America

WHEN a professional social worker of vision presents the indispensability of lay groups in the social work structure, I am always embarrassed. It seems to me that while we are eager to accept the honor of being indispensable, we are not always so anxious to accept the responsibility which is inherent in the honor.

This state of mind has its explanation. With the development of specialized knowledge and skills in social service came a tremendous emphasis on the function and importance of the qualified social worker. In order not to interfere with the functioning of experts, lay groups had a tendency to withdraw in all but name and financial support from their share in social planning. This withdrawal was based on a failure to recognize that without the active participation of lay community thought this social planning was doomed to only a limited success. Sooner or later the professional workers and planners would come up against a high wall built of community antagonisms and community ignorance.

I imagine we have to thank the last six years in large measure for dispelling this illusion. We are told repeatedly today that a community social program must, to use some one else's words, "have its roots deep in lay soil." The lay members of boards and committees and the great mass of volunteers are the top soil. Our problem is the fertilization of this soil so that the tree of community social planning shall never lack for nourishment.

We cannot accept the honor of being invaluable top soil without accepting the responsibility for its condition. It is not so easy as going to a seed store and asking for a bag of Vigoro. Education cannot be bagged, crated, nor wrapped in cellophane, and education is what we must spade deep into the soil of the community if we, the lay groups, are to meet the responsibility which today is given us.

This responsibility was not so strenuous a short time ago. We thought we were meeting it adequately if we contributed funds, if we served on boards to keep a casual eye on expenditures and to see that the agency continued to be one with which we wished to be associated, or if we worked willingly when asked—provided the job were not too boring, messy, or over-tiring.

Modern social thought defines our responsibility differently. We laymen must know a lot:

The theory and thought behind social work
All the social needs of our community, which are essential, which luxuries
Whether these needs are adequately or inadequately met
Whether the particular agencies in which we are interested are vital to the community program
Whether these agencies handle their jobs according to the highest standards of modern social practice

Knowing these things, we are told we must act as co-planners with the professional groups; we must supplement the work of professionals with intelligently directed and intelligently prepared volunteer service; and we must act as interpreters of the community to the professional groups, of the professional program to the community.

It is obvious, then, that the primary, the all-important job for lay groups interested in the welfare of the villages, towns or cities in which they live, is the education of themselves along the lines just mentioned.

Many of us retort, when asked about plans for such education, that the making and carrying out of plans for the

*Presented at the opening luncheon of the Lay Division of the Rochester (N. Y.) Council of Social Agencies, September 11, 1935.

creation and feeding of intelligent community thought along social lines is the job of the professional group. We are lazy and unjust when we give this answer. I believe we should reasonably expect individual agencies to do all in their power to require training for their boards, committees, and volunteers, but the tremendous loads carried by professionals and agencies in all fields quite evidently prohibits them, however willing they may be, from assuming the broader educational job.

Before we consider the ways in which this educational plan should be tackled, I would like us to examine a few states of mind fairly common among lay groups which we should try to eradicate as quickly as possible.

UNDESIRABLE ATTITUDES

The first of these is the pat-myself-on-the-back, self-righteous state of mind. "Am I not nice to be doing this welfare work? For once, somebody is doing something for nothing." It is almost inconceivable that any one could still feel this way. Once upon a time we thought of welfare work as helping the other fellow. When we coöperate in welfare programs today we are helping ourselves and our children just as much as the other fellow.

We know what well administered public and private relief means to our pocketbooks as opposed to inefficient and wasteful methods. We may be ever so careful about health rules for our own children but all the precautions within our power will be in vain if the public health program is ineffectual. We may give our children fine standards of living, fine ideals, the best that education has to offer, but we know from bitter experience that they will have little chance for peace and happiness in the years to come if the communities they live in are battered and scarred as they are today.

The next failing I would like to call to your attention is "Agency Pride." This has several forms, one of the most vicious of which I call "ancestor worship." I know boards of agencies which keep right on electing daughters and granddaughters of founders, and of the founders' friends, without any regard for capabilities—and they elect them for life! Some of these agencies follow policies and methods that bear no relation to present-day conditions but are followed because the ancestors thought well of them.

Then we have agency jealousy. Boards and individuals suffering from this are not as concerned with community good as they are with their own annual reports. Some one has said rightly that rivalry between agencies is a betrayal of community confidence. The same may be said of rivalry between committees of the same agency.

Two other far from commendable states of mind are lay superiority and inferiority complexes. In the first case lay boards prefer bossing the professionals working with them, to a free interchange of opinion. In the second case the lay mind feels that its opinion is valueless.

These two complexes disappear with the realization that real accomplishment must have behind it a complete fusion of professional and lay thought and purpose. Such fusion is possible only when laymen know enough of their community and of the theory of social work to be able to talk easily with professional groups.

I do not mean we should learn the professional jargon. I do not mean adopting a professional point of view. It seems to me that, to be valuable, lay groups must preserve the integrity of lay thinking; but we must base our conclusions on knowledge, not on guess work, ignorance and prejudice.

WHAT KIND OF EDUCATIONAL PLAN

A satisfactory educational program, I believe, cannot be arranged on a one-year basis, but must be planned to cover a number of years. It must offer many things.

First, orientation in the theories of social work and in the philosophies behind public and private relief. This grounding may be the hardest part of the program to put across to a committee on arrangement. Some will suggest that individual reading is all that is needed to cover this ground, but few

of us are experts in research and it takes an expert to dig the meat from the great mass of literature dealing with these subjects. Others will say that nobody wants to listen to a lot of theory, that everybody wants to get right down to cases. This impatience must be curbed, for unless the theory becomes as familiar as a pocket searchlight to an individual and is used as readily, the facts can never be placed in proper focus. Furthermore the meeting of immediate difficulties without this background results in a failure to consider basic causes, without which consideration the difficulties cannot be permanently eradicated.

Second, should come a study of life in your community: its vital statistics; city and county government and their relationship to the social program; the functions of the various public and private welfare agencies and of the coördinating units, chests, councils, etc. Applying the theories we have evolved through the first part of the program, we may judge what is good in the community plan, what is bad so that when the time comes for correcting the flaws, the lay coöperation may be intelligent and constructive.

Then should follow more specialized studies of work in various fields such as child care, family welfare, character building, and health—this to increase the knowledge and efficiency of groups working in these fields and also so that the right hand may know what the left is doing.

There also might be offered an opportunity for the discussion of volunteer service: the recruiting of volunteers, their training and placing, the necessity for trained supervision, and the use of volunteers as interpreters to the community of the work of the agencies.

Also of infinite value should be a study of methods for individual board analysis: how boards should be made up, the rotation of offices and committees, the training of new members and the more specialized training of older members; relations with the professional staff and once more the use of board members as interpreters of the work.

And finally it would seem that a thorough educational program should provide a continued opportunity for the discussion of pending and adopted welfare legislation, local, state, and federal.

I think I have implied that this program should be designed for board and committee members as well as volunteers. I would suggest that it is important also to keep in mind the enlistment of the interest of various nonactive groups—potential energy for the development of an enlightened public opinion.

There will be place in this long-range program for many types of meetings, mass meetings with well known speakers whose topics shall have wide general interest; large and small group meetings with speakers on more specialized subjects; open forums, institutes, round table discussions, and field trips. Infinite pains are needed for it seems a very complicated and a very large puzzle.

Yet it is not such a large order when considered from the point of view of the enormous amount to be done before our communities bear the faintest resemblance to the communities we envisage as possible. In an article in the *Survey* several years ago, Eduard Lindeman quoted Emerson to describe the way many of us are feeling today:

> "Our torment is Unbelief, the uncertainty as to what we ought to do; the distrust of the value of what we do. . . . A great perplexity hangs like a cloud on the brow of all cultivated persons, a certain imbecility in the best spirits, which distinguishes the period. . . It is not that men do not wish to act; they pine to be employed, but are paralyzed by the uncertainty what they should do."

There is one point on which we can have no uncertainty, no unbelief. If lay groups are to accept the responsibility as well as the honor of being indispensable in the social structure, we must make such plans for our education as will enable us, with the courage born of knowledge, to fill the rôles of coplanners and interpreters of the social program.

Another Vote for Generalized Nursing

By GRACE ROSS, R.N.

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IT might be said that this article is devoted to a very shopworn subject, except for two conditions: One, that public health work is not uniformly developed in all communities, the other, that what we thought was progress yesterday may have reached obsolescence today. In other words, a critical survey is in order any time these days, and the request that Detroit present a critical analysis of results from its generalized and specialized services is complied with, because of it.

Generalized nursing started in the Department of Health of Detroit in 1920 because it was expected to be a means of reducing costs, of eliminating duplication, and of protecting the families from irritating over-visitation.

A district of 100,000 people was chosen, and 18 nurses were assigned to it. They had had experience in every branch of the medical bureau before being assigned. The program included every type of service excepting routine bedside care of the sick which was given by the Visiting Nurse Association.

A report of the experiment by Dr. Carl E. Buck appeared in the Detroit Weekly *Health Review* of June, 1923. It contained the following figures covering five months of work.

The table below shows that the generalized nurse gives more services in every type of nursing except "other."

An analysis was also made of the distribution of services. (See following page.) These were crude figures and of little use for present comparison but they indicated the right direction and encouraged future expansion.

Growth was not so rapid as desired because the Department was determined not to expand until adequately prepared nurses were actually ready, bag in hand. There was and still is considerable dependence on magical powers in preparing public health nurses. A young woman can receive her nursing education in a hospital which is in no wise concerned with preparing her for community service, in fact, for anything other than for getting its own particular patients nursed. She can then be engaged by a public health agency which has no special program for preparing her for the duties with which she is thoroughly unfamiliar, and straightway she becomes not only a "specialized nurse", which implies special preparation in at least one field, but becomes a "generalized nurse"—which implies preparation in all the branches of public health service. You say this sounds ridiculous—a magical wave of the hand and behold!—but unfortunately it describes the facts.

NUMBER OF SERVICES PER NURSE

	Specialized District		*Generalized District*	
Type of service*	Total services	Number of services per nurse	Total services	Number of services per nurse
School health	28,480	187.3	4,533	249.1
Communicable diseases	16,616	109.3	2,891	158.8
Tuberculosis	10,796	71.0	1,482	81.4
Child welfare	24,639	162.1	8,078	443.8
Other	4,999	32.8	354	19.4
Totals	85,530	552.5	17,338	952.5

*The term "service" in this particular study did not mean visit but the kinds of service rendered. For instance, if a nurse made a tuberculosis visit and gave prenatal instruction also, this was 2 services. A uniform definition of a service was used.

DISTRIBUTION OF SERVICE

Type of service	Specialized nursing Nine-tenths of the city % of total services	Generalized nursing One-tenth of the city % of total services
School health	33.3	26.1
Communicable diseases	19.4	16.6
Tuberculosis	12.6	8.5
Child welfare	28.8	46.6
Other	5.8	2.0

The Department in Detroit was determined not to have that kind of personnel and the only means of preventing it was to make possible, first, adequate preparation, university brand, and second, continuous staff education. So the Department set about to cooperate in the establishment of a public health nursing course, first at the University of Michigan in 1920, and later, locally, at Wayne University in 1930. Not only are the minimum requirements of the National Organization for Public Health Nursing helpful in safeguarding the quality of personnel for generalized work, but the matriculation requirement of the affiliated university is also. Since that time generalized service has been extended to 64.6 per cent of the total population. This employs 54 per cent of the staff. In fact, additional nurses are already prepared for the time when it is advisable to open another district.

ADVANTAGES IN DOLLARS AND CENTS

The table below gives the present facts and figures in Detroit:

In other words, it takes 24.5 minutes to make the average call in generalized work and 26.8 minutes to make the same in specialized, a small item for one call, but for the above visits, it is equivalent to the working days in almost four years—in actual money over $5,820.

However, it is almost impossible to make a comparison between these figures because there is really no Simon Pure specialization in the Department today as there was in nine-tenths of the Department in 1920. In fact further analysis of the above "specialized" visits shows that 10 per cent of them are visits not rightly belonging to the Division in which they occur. In the School Division last year this reached 23 per cent. Nurses trained to do family work find it impossible to ignore problems even when they are not made responsible for them.

Two other points may also be mentioned here. The first that the increase in child welfare visits—is still justified in the light of our present ap-

FIELD NURSING VISITS BY SPECIALIZED AND GENERALIZED NURSING JUNE, 1934—MAY, 1935

	Specialized	Generalized
Child welfare*	50,352	172,103
School health	45,434	74,670
Communicable diseases	55,981	77,677
Tuberculosis	16,369	35,492
Venereal diseases	1,927	4,654
Other	14,221	19,001
Total	184,284	383,597
Total number of hours of field time**	82,506:20	156,439:15
Number of field nursing days	11,000.8	20,858.6

*Includes prenatal, infant and preschool service

**In this study 7½ hours' field time was used as a field nursing day and visits include travel time.

NUMBER VISITS PER NURSING DAY

Type	Specialized	Generalized
Child welfare	4.6	8.3
School health	4.1	3.6
Communicable diseases	5.1	3.7
Tuberculosis	1.5	1.7
Venereal diseases	0.2	0.2
Other	1.3	0.9
Total	16.8	18.4

preciation of early child care. The second is about "other" visits. This means "trouble cases"* largely. It is decidedly in favor of generalized work that it has so few "trouble cases".

There are other advantages found in generalized service and the following figures seem to justify some of the early assumptions.

Because the local course in public health nursing speeded up the program, expansion really got under way by 1930.

teach the program all at once than piecemeal. The difference in time favors the latter method by approximately 30 per cent.

INTANGIBLE ADVANTAGES

So far we have been concerned with the quantity and costs of results. There are quality results also in generalized nursing, of tremendous importance to the persons involved although they cannot be measured in dollars and cents. The most important

AMOUNT OF MONEY SPENT FOR TRANSPORTATION

Crude average per nurse per year

1928-29	$29.11
1929-30	27.59
1930-31	24.61
1931-32	20.18
1932-33	16.29
1933-34	17.65
1934-35	18.20

August 1930 another large district opened
Sept. 1931 " " " "
June 1932 " " " "
July 1933 " " " "
and four others considerably extended

A scarlet fever epidemic in 1934 and a measles epidemic in 1935 occurred in outlying areas where bus service rather than street car service was necessary. Even with this necessary increase the difference in the 1935 rate and the 1929 rate makes an annual saving of approximately $4,000.

At the present moment only 36 per cent of the staff are not fully prepared to do generalized work and yet "specialized" nurses contributed 54 per cent of all resignations which occurred from January, 1932 to June, 1935. There are always many factors to consider but this appears significant especially when the cost of turnover is remembered.

The criticism has been made that the introductory period for generalized work costs the agency too much. The fact is that nowadays a public health worker must know the whole field. We advocate seeing the "whole child" and to see him in relation to the whole family situation. Such policies presuppose preparation in the whole field. Moreover the nurse must be transferred some time, and it is easier to

persons to benefit are, of course, the members of the family.

The field nurses and the field supervisors agree upon the following statements in relation to these advantages:

The families are better served because one nurse has all the facts and in the light of them can make sounder plans and give sounder advice and instruction. In other words first things come first. One nurse expresses it when she says, "A nurse would not urge a mother to spend her money to correct a defect in her school child which could wait, if she were about to be confined and had her money saved for that purpose. A generalized nurse making the school call is able to change the emphasis and care for the prenatal situation first. When the time comes for caring for the defect she succeeds because of her being able to stand by and help during the prenatal period."

Having one nurse eliminates the need for securing the family history more than once and one nurse, visiting long enough, gets all the true facts.

The family feels closer to one nurse.

*By "trouble case" is meant the type of patient, family or situation a nurse is unable to manage alone. The tuberculous father who will not go to a sanatorium, the mother who refuses care for her child, etc. These cases are handled by a department of special investigation.

A typical reaction is that of a mother who said to the nurse in quest of tuberculosis contacts, when she mentioned a particular school, "then you must know my Johnny."

One supervisor says, "The family gets better service because they have a better informed, more interested, more alert individual supervising their health."

Also, the general work is better promoted. Because she handles all problems, the nurse sells the Health Department and not one activity. Social hygiene especially can be taken care of best when considered just another of the several family problems—it has to be a "family" problem just as tuberculosis is and cannot be anything else.

Each family is discussed with only one supervisor instead of with several.

Having several reasons for which to go to the same family, the nurse finds enough time in which really to accomplish changes in health habits.

When the family is a private physician's case, it eliminates the need of several nurses making contacts with him.

One comprehensive family record is at hand instead of several more fragmentary ones.

One nurse contacts the social agency instead of several.

In fact it promotes the work too well—it tends to uncover more work than the number of nurses can take care of.

EFFECT ON THE NURSE

We find the system of very great importance to the morale of the nursing staff. Generalized work is more challenging, interesting, educational and broadening, and has more variety—hence has less repetition and monotony than specialized. It presents more opportunities for health teaching. It gives the nurse more occasions to demonstrate her ability, thus gaining the confidence of the family. The greater responsibility makes her feel all the more the importance of her task.

Quoting the nurses:

> "I have received more satisfaction and enjoyed my work much more during one year of generalized work than during my six years of specialized work."

> "Nothing can take the place of generalized work. Unless a nurse is a laggard she can always find more work, more variety, and more stimulation in her work than she can possibly find in specialized work."

Of the seventy-four nurses who have done both types of work, sixty-eight say they hope they will not again be asked to do specialized work permanently although many feel they do still better generalized work after specializing for a short time.

In closing it is well to state that the Detroit experience has made it clear that special supervisors continue to be necessary for administrative purposes, for planning and promoting, but that the connecting link, the "coördinator" between them and the generalized districts for all purposes, is a generalized supervisor thoroughly familiar with both fields but whose fundamental training is a generalized one.

Ideally the specialists should be trained first in generalized work before specializing, and of equal importance, generalized supervisors are improved by having subsequent experience in special activities. In other words it appears that the supervisor and the nurse need to see and think first in family terms, but the greater their fund of specific information and the greater and more detailed their experience the better, and the better they serve the whole community through the family.

The Red Cross in a Program of Education and Prevention

By I. MALINDE HAVEY, R.N.

National Director, Public Health Nursing and Home Hygiene and Care of the Sick, American Red Cross

NURSES everywhere have known of Red Cross work in instances where it seeks to stem the tide of want and woe. Many do not know of the American Red Cross in its wider, more far-reaching and often more dramatic program of education and prevention.

JUNIOR RED CROSS

How many of us know that our American Junior Red Cross carries on friendly correspondence with Junior Red Cross members in many other countries? How many of us know that these same Juniors carry out in their annual program three definite educational phases through their "Service To Others," "World-Wide Friendship," and "Fitness For Service"? With the enrollment of thousands of school children actively interested in these three things, is it any wonder that we look with faith and hope to what they will accomplish as adult members of the Red Cross? Through them we have reason to believe that the day will come when a League of Nations, to prevent war through legislation, will not be necessary, but that the world-wide friendship created through our Junior Organization will eventually make war an impossibility.

FIRST AID

Well do we know what the aftermath of the following quotation means in human suffering: "In 1934, 36,000 persons were killed upon the highways of the United States, and of the 1,255,000 who were injured, 105,000 were permanently crippled." This is a statement made by our First Aid Service. Today one of our own Red Cross nurses lies helpless in a hospital after an automobile accident a year ago. She will never walk again. Word reached us only a few days ago of the death of one of our public health nurses in an automobile accident.

In its carefully planned program the Red Cross First Aid and Life Saving

Rural America welcomes the Red Cross Nurse

Service is seeking accident prevention as well as teaching all America to render intelligent "First Aid" on land or in water. We are familiar with its years of instruction in first aid and water safety. This Service is now broadening its program to include safety on the highway, a plan insuring to the highway traveler safe and sane first aid in case of accident. We who see the accident victim brought into the hospital so often in a hopeless condition because little or no first aid was administered, can well appreciate the program of education that this service will carry during the year throughout the entire country.

Just under the total given for automobile fatalities, appears the startling figure of those from accidents that occur in the home and on the farm. One accident every six seconds is the rate reached last year. Though it is not the purpose of the Red Cross to lead people to believe that they are safer most anywhere than in the home, all nurses will be interested in the recently developed program of Farm and Home Accident Prevention. Again, as in its other programs, education and prevention sound the key note.

WAR SERVICE

War does not end with an "Armistice." Disabilities, physical or mental, call for continuing Red Cross service: Assistance in filing pension claims; endless tracing of doctors or "buddies" who can make affidavits to prove service connection of the disability; care of families of veterans when the latter must return to a government hospital for treatment; social problems of every variety—thus the Red Cross serves hundreds of thousands of disabled veterans of any war or peacetime service.

In every Army and Navy Hospital Red Cross hospital social workers provide the social service required by the medical staff for diagnosis and treatment of active service men.

Red Cross chapters all over the United States render Home Service for veterans and active service men and their families.

DISASTER SERVICE

Some of you have been called for disaster service. The call has come through someone on your local Red Cross Committee, proving repeatedly to us how quickly these committees get on a job in an emergency. Had we no other need for Red Cross enrollment than this efficient service, we would find in it sufficient reason to interest the young nurse graduate in this enrollment.

You read of the dust storms, but do you know that 39 nurses worked long and faithfully to save lives during and following these storms?

Perhaps you have read also of some of the other 128 disasters occurring during the past twelve months in which the Red Cross has engaged actively in both remedial and preventive programs. The hurricane on Labor Day, just passed, that worked such havoc on the Florida coast is still requiring the services of the Red Cross. Today in a county in western Kentucky a staff of eight Red Cross nurses is busily engaged in waging war against a typhoid fever epidemic to the end that such an epidemic can never again occur in that county.

Our records are full of the work of rehabilitation that follows a disaster. The greatest service, however, is in the education of the people in disaster prevention and in working out the solution to their own problems.

PUBLIC HEALTH NURSING AND HOME HYGIENE SERVICE

There are in the United States 550 chapter public health nursing services, financed in full or in part by Red Cross funds, with some 765 public health nurses ministering to the sick and giving health instruction.

This is an old story to many of us but an ever new one to our service. The heroism of our nurse in Alaska, Madeline DeForas,* the courage and self-sacrifice of the nurses in our itinerant services, remind us daily that pioneering in nursing service is still going on. The steady and faithful efforts of our nurses everywhere, who are carrying on

*This magazine is hoping to have a story from Miss DeForas in 1936.—*The Editors.*

public health nursing services in the name of the Red Cross, and for the most part in places where there would be no other public health nursing services, is an ever-increasing proof that the Red Cross *is* carrying out a program of education and prevention.

More than 1,500 Red Cross nurses working in hospitals and institutions or employed in private duty, as well as the full-time Red Cross public health nurses, are devoting time to giving instruction in Home Hygiene and Care of the Sick in their communities. (See page 599).

One usually associates ordinary bedroom, bath, and kitchen facilities as the background for a course in Home Hygiene and Care of the Sick, but when the Red Cross nurse gave this instruction to a group of eager mothers and girls on the floor of the Yosemite Valley a little railroad station house was the best classroom available. This was a tent-town community, with no tent large enough to accommodate a number of persons, so the station agent offered the use of the waiting room, with one restriction, that classes should not begin until after the daily train had come and gone!

During the past year classes in Home Hygiene and Care of the Sick have increased tremendously and there are many more groups eagerly awaiting this instruction. It is a challenge to Red Cross nurses everywhere. To those who have taught the Red Cross courses the Nation owes a lasting debt and to those nurses who have not yet included this teaching in their programs it presents a real opportunity for worthwhile service.

We often find that our nurses are unfamiliar with our Red Cross charter obligations, so at the risk of carrying coals to Newcastle, we quote the fourth and last objective therein set forth:

"To continue and carry on a system of national and international relief in time of peace and to apply the same in mitigating the sufferings caused by pestilence, famine, fire, floods, and other great national calamities, and *to devise and carry on measures for preventing the same.*"

And so we find our American Red Cross today more active than ever before in its program of education and prevention, seeking at all times and through its annual Roll Call "to devise and carry on measures for preventing" calamities. Still as the symbol of skilled service, we find the Red Cross nurse. To her we turn in this peacetime program of education and prevention.

Making life easier as sunset draws near

Air Sickness

Editorial Note: We are very much indebted to the Secretariat of the League of Red Cross Societies in Paris for the reproduction of this excellent discussion of *Air Sickness* which in turn was taken from an article entitled "Pathologie spéciale de l'aviateur" published in the Annals of the Belgian Royal Academy of Medicine over the signature of Charles Sillevaerts (Volume XXV, part 4, 1935).

AIR SICKNESS is to the traveler by aircraft what mal-de-mer is to those traveling by sea. Mal-de-mer is caused not only by the rolling motion of the ship but by enforced confinement below deck in rough weather. The aeroplane has one great advantage over the sea-going vessel in that, whereas the latter is bound to the element on which it navigates and can escape the tempest only at the cost of long deviations from its course, the aeroplane, by changing altitude, can rise above the zone of disturbance and attain a region more favorable for navigation.

The symptoms of air sickness are most frequently observed in the stuffy atmosphere of closed commercial planes carrying passengers over long distances; persons with delicate digestive organs, however, are just as liable to its throes in an open plane.

At certain altitudes, air sickness might be confused with the sense of oppression experienced by mountaineers when attaining heights at which the air becomes rarefied; in the case of many subjects, the symptoms are very similar. Nevertheless, at the heights which are the most frequent cause of mountain sickness, it is exceedingly rare to encounter atmospheric disturbances of a nature likely to provoke air sickness in the pilot of an open plane.

DETERMINING FACTORS IN AIR SICKNESS

Sudden changes of altitude caused by conflicting air currents. These violent plunges and equally violent recoveries exercise a profoundly disturbing effect on the nervous system and on the digestive organs. The swaying movement, which is infinitesimal and usually endured without discomfort by those seated around the longitudinal axis of the machine, can also contribute towards air sickness. In the case of otorhinolaryngological subjects, the violent reaction on the aural cavity is the principal cause of air sickness.

Professor Quix, of the University of Utrecht, who has given much study to "aeronautical troubles" arising out of disturbance of the semi-circular canals and the otolithic system, has ascertained that mal-de-mer is produced by abnormally strong and non-physiological irritation of the otolithic apparatus. To determine this condition, it is not essential that the pitch and toss should be very accentuated; they need only be sudden and frequent. A fall of a few yards, provided it is rapid enough, is sufficient, as are the slight and oft-repeated oscillations around the longitudinal axis of an aeroplane, to provoke intense otolithic irritation, and sensitive persons soon become incapable of en-

during these continual movements without discomfort.

CONTRIBUTORY FACTORS TO AIR SICKNESS

Atmosphere of the Cabin—Conditions of ventilation, heating, noise of the motor, and smells are of such importance that the majority of physicians concerned with civil aviation now envisage air sickness as a form of accidental asphyxiation due to defective hygiene of the cabin rather than as a result of faulty adaptation to the motion of the aeroplane. They consider it preventable if certain precautions are taken by the constructors and by the passengers themselves. It has been observed that, even in perfectly calm weather and in the entire absence of movement, several passengers in overheated and ill-ventilated cabins have been incommoded, whereas the same persons, traveling in another type of plane in similar or less good atmospheric conditions, have experienced no discomfort at all. The same phenomenon may be observed in the case of sea-sickness: a passenger who can endure a fairly rough sea provided he remains on deck would probably succumb to mal-de-mer if he stayed shut up in his berth.

Optical Vertigo—Optical vertigo is nothing more than a complication due to the swaying movement around the longitudinal axis of certain types of aeroplane. In planes with high wing loading, where the cabin is below the wings, the passenger has a clear and unobstructed view of the horizon, without any points of comparison to disturb his vision. Consequently, there is little or no unpleasant discordance between his visual impressions and his sensations from the swaying of the plane.

When the cabin is above the wings, as in the case of planes with low wing loading, much of the outlook is masked and, during the movements of the plane around its longitudinal axis, the visual impression of rolling will be much greater than the sensation felt, in view of the numerous points of comparison. This discordance is still further aggravated by the different items of rigging coming within the passenger's field of vision. It produces at first an unpleasant sensation, which soon becomes painful, often to the point of causing nausea and vomiting, thus completing the work already begun by the rolling and the stuffy atmosphere of the cabin. It will therefore be seen that optical vertigo is a result not only of the movements of an aeroplane but also of its construction.

Ventilation—Up to a few years ago, the majority of aeroplane cabins were ventilated from back to front on account of the downdraught produced during flight in the cockpit. This system was generally insufficient, in addition to which it presented the double disadvantage of bringing into the cabin the odor of the fumes from the exhaust and from the toilet situated at the back of the plane. In the latest types of machine, ventilation is from front to back and passengers are advised not to open the windows. Additional fresh air is provided, if required, by an apparatus placed beside each seat, so that a passenger can have as much air as he wants without inconveniencing his neighbors. This arrangement represents a great progress and should appreciably diminish the incidence of air sickness due to faulty ventilation.

Heating—Another frequent cause of air sickness is defective heating. Planes fitted with water-cooled motors are immune from this disadvantage; the water heated by the motor circulates through the cabin before returning to the radiator and produces an agreeable and easily-regulated warmth exempt from odor. In the case of air-cooled motors, however, the problem is much more difficult. Here the warmth is diverted to the cabin by means of a sleeve fitting over the exhaust and opening towards the front to allow the air to enter. The only satisfactory solution—and one which must sooner or later be adopted by all the large passenger planes—would appear to be an auxiliary dynamo to provide the necessary current for lighting, heating, cooking, etc.

Noise—It is very problematical if the noise of the motor plays any great part in producing air sickness. There can be no doubt, however, that it is a cause of

irritation to nervous people and if some means could be found of silencing the motors and propellers it would unquestionably add to the comfort and pleasures of air travel.

The Psychic Factor—The importance of the psychological factor is incontestable. The optimistic passenger who embarks with the conviction that he will escape air sickness stands a very good chance of doing so. The little paper bags suspended from the back of each seat often exert a deplorable influence on the passengers by reminding them of the frequency of air sickness. It is not suggested that they should be done away with altogether, but they might at least be placed in a less conspicuous position, say under the seat.

Contagiousness—There can be no doubt that air sickness, like mal-de-mer, is contagious. It is sufficient for one person to be ill for his example to be promptly followed by others, even in calm weather. At other times, in spite of a rough passage, no one is affected.

Concentration—As in the case of sea voyages, the act of fixing the attention on something will often keep air sickness at bay. If passengers are given a map or a descriptive guide enabling them to follow the itinerary of the flight, their minds will be kept occupied to the exclusion of outside sensations. From this point of view, the modern air liners are particularly well equipped; there are bars and smoking rooms, and passengers may circulate as they please along the promenade deck which runs from the back of the plane to the pilot's cabin where they may watch the crew at work and enjoy a fine panoramic view of the landscape over which the plane is flying.

Medical Aids—The different remedies and panaceas prescribed for air and sea sickness undoubtedly have a powerful psychological effect on those who take them; far be it from us to attempt to shake the faith which heals.

SYMPTOMATOLOGY

The symptoms of air sickness are very similar to those of mal-de-mer and may take three forms, *viz.:*

Cephalic—The onslaught of air sickness is heralded by yawning, followed by violent headache and buzzing in the ears, profuse saliva and nausea; in certain cases, these symptoms are replaced by drowsiness or a feeling of nervous depression.

Gastric—An indefinable sense of discomfort quickly followed by nausea and continual vomiting. The fact that the stomach is empty renders the act of vomiting all the more painful.

Gastro-Cephalic—In this form, the characteristic symptoms of the two others are united.

Air sickness does not always take the same form in the same person.

TREATMENT

Preventive—This is by far the most important form of treatment, for air sickness is much more a question of hygiene than of therapeutics.

It is a matter of common knowledge that mal-de-mer can be avoided, or at least considerably mitigated, if a recumbent position is maintained. This, unfortunately, is not possible as yet in an aeroplane, but it lies within the power of the aircraft constructor to eliminate the more important of the contributory factors, *viz.*, faulty ventilation, heating, etc. When this has been done, the incidence of air sickness will automatically fall by two-thirds.

The air pilot has also a responsibility in this connection; whereas it is quite impossible for a ship to sail eternally on a calm sea, it is relatively easy for an aeroplane to avoid zones of disturbance, and this the pilot should endeavor to do for the sake of his passengers.

The other preventive measures are incumbent on the passenger himself. The question is frequently asked whether one should or should not take a meal before embarking for a flight. The general consensus of opinion is that no deviation need be made from the traveler's usual habits, though it is wise to refrain from too copious, too indigestible, and too hasty a meal at such times.

All the remedies prescribed for mal-de-mer have been tried against air sick-

ness, with varying results. This diversity of effect must be ascribed to the individual factor. Nervous subjects react very favorably, as a rule, to autosuggestion, concentration of will power, or a harmless remedy in the efficacity of which they have faith. The practice of tightly binding the abdomen in flannel from the thighs to the armpits sometimes gives good results.

Far the best way of avoiding air sickness is to become engrossed in an interesting book or a guide of the itinerary, or, if the cabin is equipped with large windows commanding a wide panorama, to contemplate the landscape.

Curative Treatment—There is nothing to be said about this, as the present conditions of aviation render any form of curative treatment impossible during flight.

Like mal-de-mer, air sickness automatically ceases, as a general rule, as soon as the plane comes to earth. It sometimes happens, however, if the passage has been particularly rough, that the phenomena persist to a certain extent during the car or train journey consecutive to landing. In such cases, relief is usually obtained by opening a window and reclining in a recumbent or semi-recumbent position.

The photograph used in this article is through the courtesy of United Air Lines and the "Rockefeller Center Weekly."

PHOTOGRAPHS PLEASE!

DURING the last few months the N.O.P.H.N. has had no less than twenty-five requests for photographs showing the public health nurse at work, from the following agencies:

National Health Council
Community Chests & Councils, Inc.
New York Times
Fifteen visiting nurse associations
Three writers who were preparing
(1) a book
(2) a newspaper article
(3) a magazine article
Rockefeller Center Weekly
Nursing Information Bureau
A board of health

It has not been possible to keep an up-to-date, attractive supply of photographs on hand. Yet to represent public health nursing pictorially in an adequate way is surely a responsibility of the N.O.P.H.N. and it disturbs us when we are unable to fill requests and to know that the picture of the nurse that is finally published for nationwide distribution may be totally wrong—a nurse in white, a nurse in high heels, a nurse sitting on the patient's bed, a nurse in uniform—smoking—all of which we have seen recently.

Will you share your pictures?

If you have any clear, glossy prints of the public health nurse at work—in office, home, clinic, school, industry, or just "on the way" in city or country, may we have a copy? If it is a picture we can use and if you have gone to any expense in getting an extra copy for us, we will gladly pay for it, and we will publish the names of contributors to this cause! With the picture will you please send us the following information:

(1) May we use the picture for publicity purposes without credit to your organization? If not, how do you want the credit line to read?
(2) May we cut off some of the picture if only a part of it is needed?
(3) Is there a charge for the picture?
(4) Has the picture been used in any newspaper or magazine of wide circulation? If so, permission to use it must be obtained from the publisher.

Please send your pictures to the National Organization for Public Health Nursing, 50 West 50th Street, New York, N. Y.

And Thank You!

A Program for Staff Education

Editorial Note: What is most needed in the field of public health nursing today? The N.O.P.H.N. *Survey of Public Health Nursing* told us all too plainly: better teaching. Better teaching depends on a knowledge of method and of facts. As assistance to groups of nurses and nurses working alone, who wish to enrich their teaching and catch up with recent scientific developments, the N.O.P.H.N. is offering suggestions in the form outlines for staff study programs or institutes with a selected list of reference reading. The first of these outlines concerns tuberculosis. We are greatly indebted to the National Tuberculosis Association for assistance with the reading lists, and to Mrs. Violet H. Hodgson, formerly assistant director of the N.O.P.H.N., for material and outlines prepared by her in connection with her institutes.

It is suggested that in communities where more than one public health nursing agency is working, a plan of joint staff conferences or a joint institute be carried out, and that where the material calls for specialized technical knowledge, outside speakers be invited to present the subject. It is essential to have this expert leadership if the material is to be handled in an institute. The N.O.P.H.N. and the National Tuberculosis Association will be glad to make suggestions for institute leaders if it is not possible to find local or state talent. The reading suggestions are purposely limited—a further bibliography is obtainable from the N.O.P.H.N. and N.T.A.

THERE are two groups of nurses to be reached in any program of staff education: the group that has sufficient breadth of vision to make immediate application of abstract statements to organization policies and procedures, for whom lectures and discussions become actually educational, in that they have a direct and salutary effect on existing methods, and a second group which is preponderantly concrete minded, which will derive greatest benefit from an educational program which combines the abstract with specific illustrations of its practical application to field situations. Where it is not possible to separate the two groups, and it seldom is, the second method offers the greatest assurance of reaching the largest number, and thereby justifying the time, effect, and expense of planning for this indispensable device in staff growth and development.

It is not always easy, with or without an item in the budget, to procure qualified speakers outside of the organization. It is infinitely more difficult to find individuals on the staff who know their subject thoroughly and at the same time are able to hold the attention of their fellow-workers. Furthermore, the "outside" speaker has the advantage of prestige which accompanies a visitor. He or she is also favored with the attention-getting attribute of a new viewpoint, which constitutes a distinct essential in any effective program of education. The visiting speaker, on the other hand, may have the decided disadvantage of unfamiliarity with the organization program, which may offset the assets by the liability of "missing the mark" and failing to bring about speedy and favorable changes in content, procedures, and techniques of the staff.

A staff education program must be more than a list of subjects presented by a series of speakers, however formidable their reputation may be for knowing their subjects. It should be more than an "inspirational" address. Even richness of subject material will not suffice. *There must be improvement in the nursing service to the community.*

When all the assets of the "known" and "strange" speaker or discussion leader are carefully considered, the chances are that the person who is not only well informed on the subject but is thoroughly familiar with the organization program, and intimately acquainted with the needs of the entire staff, will be more likely to succeed in carrying the message beyond the classroom into the home. Unless this transfer is made, it is questionable whether any program is truly educational. In other words, it must be dynamic and not a static experience. Since no amount of advice, however scientifically accurate it may be, given by the nurse to the family can be classified as teaching until the family has been "motivated" and a change of thinking and action effected, so no "staff educational

program" is worthy of the term, until a similar change has been brought about in the nurse's performance in the field.

In these days of budget curtailments, it is both economical and professionally desirable to plan an educational program "of, by, and for" the staff. If the organization possesses an educational supervisor, this is obviously her function. Where such a position does not exist, it falls to the lot of the director or her assistant to assume this responsibility. In many, many places, the nurse working alone will have to study alone. A knowledge of subject matter can be gained by reading.

Skill in presentation is largely a matter of interest and practice. Here again, it is illogical to expect the nurse to become an increasingly effective teacher in the home, unless the executive staff likewise improve the qualities of leadership and teaching which they should possess by virtue of their position on the staff. If the community is, in a measure, the laboratory in which the nurse develops skill in teaching, the staff in turn serves in a similar capacity to the executive in qualifying her for leadership in the teaching field.

Success in conducting a staff education program then implies:

A thorough knowledge of the subject
Employment of sound principles of teaching
Interest and enthusiasm in the subject itself and the growth of the nurse as a teacher of health
Immediate application of the subject matter to nursing methods
Ability to interpret technical knowledge into simple terms, so that the uninformed and less intelligent patient can grasp its meaning
A consciousness of the ultimate consumers of the subject presented, *viz.*, the community, and the improvement of the means by which it is delivered, *viz.*, the nurse.

SUGGESTIONS FOR STAFF STUDY PROGRAM ON TUBERCULOSIS

I. NATURE OF THE DISEASE

A. Types
  1. Adult or pulmonary
     Minimal—moderately advanced—far advanced
  2. Childhood or glandular
B. Recognition of the disease
  1. Symptoms
  2. Tuberculin tests
  3. X-ray
  4. Sputum examinations
C. The tubercle bacillus
  1. Modes of transmission

Suitable guest speaker—Tuberculosis specialist, perhaps member of medical advisory committee or head of local clinic. Graphic presentation desirable through use of drawings, X-ray films, specimens, etc. When such a guest speaker is not available nurses themselves can learn much through assigned reading (see bibliography) followed by reports and discussions in staff meetings.

References—(National Tuberculosis Association* publications can usually be secured through local or State Tuberculosis Association.)

Brown and Heise, *The Lungs and the Early Stages of Tuberculosis*. D. Appleton-Century Company. $1.50

Chadwich, H. D., M.D., and McPhedran, F.M., M.D., *Childhood Type of Tuberculosis*. National Tuberculosis Association. 15 cents

Diagnostic Standards. National Tuberculosis Association. 2 cents

*50 West 50th Street, New York, N. Y.

II. TREATMENT OF TUBERCULOSIS

(Two class periods probably required)

A. Fundamentals
  1. Rest
    a. Postural
    b. Surgical
      artificial pneumothorax
      phrenectomy
      thoracoplasty
  2. Fresh air—sunshine—heliotherapy
     Use and dangers
  3. Adequate diet
     Balanced
     Problems of limited budget
     Racial customs
  4. Mental hygiene
     Adjustment to long illness and treatment plans
     Later adjustment toward return to normal activities
  5. Occupational therapy
  6. Social rehabilitation
B. Place of sanatorium and home in treatment

Suitable guest speaker—Sanatorium physician (also nutritionist, mental hygienist, social worker, occupational therapist—if available and time permits).

By use of available reading material, reports by staff members and discussion, subject may be studied without guest speaker.

References—(National Tuberculosis Association publications can usually be secured through local or State Tuberculosis Association)

Brown and Laurason, *Rules for Recovery from Pulmonary Tuberculosis.* Lea and Febiger, Philadelphia, Pa. $1.50

Burhoe, Beulah Weldon, *Social Adjustment of the Tuberculous.* National Tuberculosis Association

Bureau of Home Economics, U. S. Department of Agriculture, Washington, D. C. Recent Budget and Low Cost Food Literature. One copy each available free

III. SOCIAL AND COMMUNITY ASPECTS

(Two class periods probably necessary)

A. Incidence
   Age—sex—occupation
B. Vital statistics
   Death rates—local, state, national
   Reduction in recent years
C. Brief history of the tuberculosis movement
D. Community program for prevention and control
   1. Health education
   2. Case finding
      new cases
      contact cases
      post-sanatorium cases
   3. Resources for care and diagnosis
      tuberculin test
      laboratory facilities
      clinics
      preventorium
      sanatorium
      home care

Suitable guest speaker—Health officer, executive secretary or officer in city or State Tuberculosis Association.

If this subject is discussed without an outside speaker, resources and needs of your own community should not be forgotten.

References—(National Tuberculosis Association publications can usually be secured through local or State Tuberculosis Association).

Castigliani. "History and Background of Tuberculosis," in January and February, 1933, *Medical Life*, 12 Morris Park West, New York City. Two for $1.00

Land Marks of Progress (leaflet). National Tuberculosis Association

Whitney, *Facts and Figures about Tuberculosis.* National Tuberculosis Association

IV. CONTENT OF PUBLIC HEALTH NURSING SERVICE IN TUBERCULOSIS PREVENTION AND CONTROL

(At least two classes probably required)

A. Function
   The public health nurse helps in
   1. Finding cases and securing medical supervision
   2. Securing reporting of cases
   3. Securing medical examination and supervision for contact cases
   4. Securing sanatorium care for patients and interpreting it to them
   5. Rendering or supervising nursing care in home
   6. Teaching personal hygiene to patient and family
   7. Helping patient and family to maintain mental and social adjustment toward a long term illness
   8. Securing post-sanatorium care and satisfactory rehabilitation of patient
   9. Securing emphasis on tuberculosis prevention in all public health nursing service
   10. Integrating services of clinic, sanatorium, private physician, health department, and other related social and health agencies
   11. Educating public opinion as to unmet needs of community for prevention, control, and care of tuberculosis
B. Methods
   1. Visit (home, office, clinic)
      Essentials for effective visit
      a. Plan based on available information concerning problems, abilities and attitudes of patient and family
      b. Knowledge of tuberculosis, community resources, and nursing techniques
      c. Skill in presentation of information—simply and in such a way that it will be accepted and acted upon
   2. Records—accurate and complete
      a. Promote better care of patients
      b. Help in planning nursing program of agency
      c. Help in research and community control
      d. Show content of service and teaching method used
      e. Help evaluate service
         1. Quantitatively (as compared with A.P.H.A. Appraisal Forms)
         2. Qualitatively—by showing results, changed attitudes, hygiene habits, etc.
   3. Health teaching to groups
      Talks and classes for children and adults

Suitable guest speaker—Nurse consultant in Health Department or Tuberculosis Association.

Discussion of cases carried by agency an effective teaching device especially applicable when staff discussion without an outside speaker is the method of presentation used. It is important to find out which of the functions listed, nurses in your community are performing.

References—(National Tuberculosis Association pamphlets usually available through local or State Tuberculosis Associations).

Commonwealth Fund. *Survey of Public Health Nursing*, page 34

Gardner, *Public Health Nursing.* New edition soon to be published

N.O.P.H.N., *Manual of Public Health Nursing*

Hodgson, Violet, *Tuberculosis Nursing for Public Health Nurses.* National Tuberculosis Association

For teaching material or distribution to patients—Leaflets of National Tuberculosis Association:

What You Should Know About Tuberculosis
Refresh Yourself (What we know about rest and sleep)
Health education bibliography
Books on tuberculosis

OUTLINE FOR TWO-DAY INSTITUTE IN TUBERCULOSIS

To be conducted by a qualified leader in the tuberculosis field

First day

10-12:30:
1. Brief historical survey of tuberculosis
2. Brief outline on "What Is Tuberculosis?"
   a. Major classifications—adult and childhood
3. Social and community aspects (Age, sex, race, occupation, etc.)

1:30-3:30:
4. Treatment for tuberculosis
   a. Fundamentals of treatment, beginning with the regimen of rest, fresh air and food established by Trudeau
   b. Modern methods
      1. Sanatorium
      2. Surgery
      3. Heliotherapy
      4. Home care
      5. Social rehabilitation

Second day

10-12:30:
1. Public health nurse—case-finding and the family
   a. Open case
   b. Contact case
   c. Post-sanatorium case
2. Community program for tuberculosis control

1:30-3:30:
3. Public health nursing and tuberculosis
   a. The nurse as a
      (1) case finder
      (2) instructor
      (3) educator
      (4) giver of bedside care

   in a generalized program
   b. Content of home visit—technique—teaching material
   c. Records

Reprints of this program will be available. Single copies free to N.O.P.H.N. members, to others, 10 cents.

THE SCHOOL TUBERCULOSIS PROGRAM

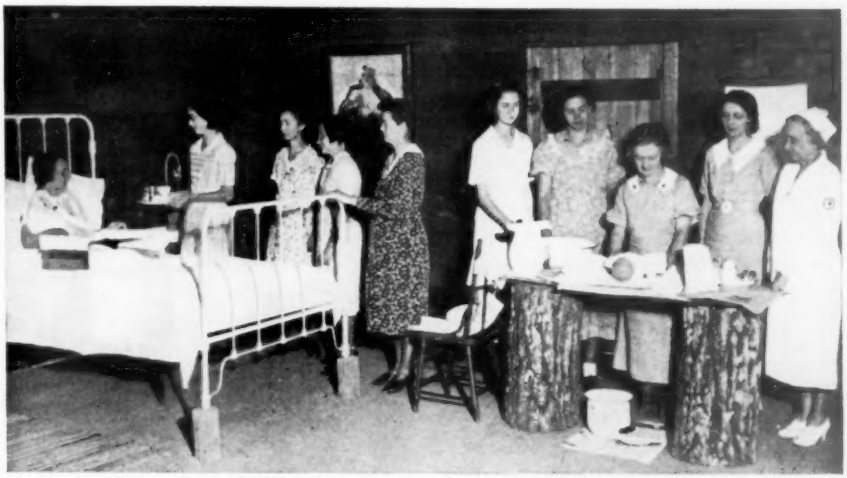
CRITICS have stated that the actual number of cases of tuberculosis found in school surveys is too small to make such an examination worth while on account of the time consumed and the expense entailed. The answer to this argument is that in no other way can the five percent of children who either have tuberculosis or indications of it be found until tubercle bacilli have made such inroads that the disease becomes manifest. Then it is unfortunately too late to do much in the way of treatment that is effective in arresting the process. Furthermore, the lectures that were given to teachers and to high school students about tuberculosis preceding the examination, the teaching of the method of doing the tuberculin test, and the interpretation of the roentgenogram to the local physician to whom the children are referred if there is evidence of disease, must be considered the most practical form of health education. The 400,000 children who have been tested and the more than 100,000 who have been X-rayed have had a personal demonstration of tuberculosis case finding that will always be remembered.

The future of this school clinic service is assured by the transfer of the program to the county and State sanatoria. These institutions have added to their staffs so that the work may be carried on in a modified way. Instead of occasional examinations of all school children, it has been decided to examine annually the pupils in the seventh, ninth and eleventh grades. By so doing three examinations will be made during the period of adolescence when tuberculosis shows its highest incidence and the adult type of the disease is more often found. It is expected that this will become routine procedure and will be carried on regularly in coöperation with the school physician.

"The Massachusetts School Tuberculosis Clinic Program in Retrospect and in Prospect," by Henry D. Chadwick, M.D., in *School Physicians' Bulletin,* June, 1935.

Home Hygiene Classes in an Official Agency*

By BRIDE LEE CAWTHON, R.N.
Director, Division of Public Health Nursing, Department of Health, Memphis, Tennessee



Courtesy of the American Red Cross

COMMUNITY need is recognized today as never before as the keystone in planning public health nursing programs. Three years ago the Department of Health in Memphis, Tennessee, saw a growing need for more care of the sick with a consequent greater demand on its nursing staff for actual bedside nursing care to the sick in their homes. This was, of course, the result of a greater number of our families becoming clients of relief agencies through unemployment, and as we knew it was humanly impossible for even a large group of public health nurses to respond to all the demands for this type of service, we felt a pressing need to teach groups of mothers in selected districts to give care to the members of their own families and to help their neighbors in sickness.

Somehow when a community need presents itself, whether it be disaster from flood, famine or disease, we all instinctively turn to the Red Cross, America's greatest mother, and because our local Chapter in Memphis typifies the true spirit of service of that loved organization, we turned to its executive secretary with the problem of organizing a class in Home Hygiene and Care of the Sick as a coöperative undertaking, using all available community resources.

Although among the forty public health nurses on the staff of the Health Department there were several enrolled Red Cross nurses, it was felt that a period of intensive preparation in teaching methods would make the classes much more valuable, so with characteristic thoroughness our Chapter executive organized a nursing activities committee, a prominent and intensely interested group of laywomen who sponsored the Home Hygiene classes and, at the start, an institute given by Miss Dunn from Red Cross National Headquarters. This was the first step in the preparation of the nurses, and on this period of intensive preparation by both Miss Dunn and Miss Dizney rests the credit for a most successful and

*Read at the Red Cross Institute, Camp Ovoca, Tennessee, June, 1935.

interesting group of twenty classes during the past two years.

WHAT KIND OF TEACHER

Too much stress cannot be placed on the professional education of the nurse. Her eligibility to enrollment in Red Cross Nursing Service presupposes high educational standards. She must be a citizen of the United States, registered according to state laws, and a member of the American Nurses' Association. She should be at least a high school graduate and have some teacher training or experience, and it is of the utmost importance that if the classes are to be given in schools the nurse should meet the minimum requirements of the teachers in the school in which she is to teach.

Her uniform, which should be worn at all classes, adds dignity to the instruction, identifies the nurse, appeals to the students generally and inspires confidence and stimulates interest in the nursing profession. For everyday duty our nurses wear a dark blue uniform with white collar and cuffs which is very attractive and much admired, but when they donned the spick-and-span white with the attractive Red Cross cap and arm insignia for certain of the class periods, you have no idea what an impression it made on the mothers. It seemed that many of them never realized before that the public health nurse is a "real trained nurse like you have when you go to the hospital."

It is evident that it might be a mistake to try to utilize the nurse in the neighborhood who graduated many years ago, who wants to get back into the nursing field but who is naturally out of touch with new and up-to-date methods of correlating what is being taught in the classes with the work being done in the community by the organized health services. The modern idea of effective health service is toward only one agency being responsible for all public health nursing work. The Home Hygiene instructor is therefore better equipped to carry on the policies of the local health service if she herself is a member of that organization and the so-called official health departments are realizing more and more that adequate care to the sick in homes is a real community need and are becoming more willing to help meet that need. We feel that classes in Home Hygiene and Care of the Sick are the answer to the new phase of public health nursing work in the official agency and that they seem to be right in line with its function —teaching health. There has been a change in the meaning of the term educational work as applied to nursing and the best public health nurse has long since given up the idea that her teaching to be effective is by words only; the public health nurse who thinks she can *tell* a mother how to care for a very ill typhoid fever patient, how to bathe a new baby or bandage a cut finger and not actually demonstrate these procedures is out of date, just as much as if she gave the most expert and meticulous nursing care and did not explain the procedures or tell the family how to avoid infection. Some one said that "Service is a valuable partner to advice and real educational work demands both." And so the wideawake public health nurse utilizes every available opportunity to teach groups of mothers the fundamentals of home hygiene and care of their own sick.

COMMUNITY INTEREST

Another valuable by-product of this course has been the community interest aroused in the health program. The Red Cross Nursing Committee, the Chapter Board of Directors and usually various other groups in the community have been asked to help finance, equip or give space for classes. The awarding of the certificates can usually be made an event. One of our nurses awarded her certificates at the meeting of the local Civic Club; every man, woman, and child in that area was there although it was held in the heart of a big city. A great deal of information regarding better health protection was given at this meeting in addition to the certificates sent out by the National American Red Cross from Washington and citizen participation in the nurse's program has already begun, which is another of the modern trends in health department practice.

Numerous instances could be cited of how far-reaching the effects of this group teaching can be. A member of a class traveling by car with several small children to a western state wrote back to the instructor that she heard of an epidemic of diphtheria in a western village and refused to allow her husband to stop there to spend the night as they had planned, saying, "We bought nothing to eat or drink there and I didn't fail to tell the man at the filling station about what a disgrace it was to have diphtheria." Or the mother who tells about her husband being seriously injured in an auto accident and that without the course she would never have been able to care for him at home; or the class member who ran to the neighbor's house in an emergency to find the baby being born too soon and who assisted the doctor so effectively that he said, "Without your help I couldn't have worked so fast or so well and we might have had trouble. Who taught you?" Or take the little fourteen-year-old girl from one of the islands on the Mississippi, who was living in the most primitive surroundings, who never entered a school until she was past thirteen; then was "given away" to a great-aunt and placed in the school for exceptional children where one of our nurses was giving a Home Hygiene course. One of her first contacts with the great world was the nurse and under a magazine picture she writes, "Our Guiding Angel and best friend," while here and there through her little notebook after less than six months of school runs a sweet philosophy of what the hygiene classes have meant to her. So might we enumerate many such examples of how what is taught in the classroom is put into practical use in the lives of the students, which after all is the objective of the entire Home Hygiene course.

If the old maxim, "Practice makes perfect," holds true what better way can a nurse improve her own teaching technique than by organizing a Home Hygiene class of twenty mothers and following the carefully planned outlines provided by the National Home Hygiene Director.

Many of us have visited the Red Cross Garden in Washington and have marveled at the exquisite beauty of the bronze statue, "The Spirit of Nursing," a monument dedicated to the nurses who died in the World War, honoring in particular Jane Delano, our leader and author of the textbook used in the teaching of home hygiene classes. But the real spirit of nursing (Miss Delano's spirit) does not stand in a sunny garden beside a white marble seat in far-away Washington—it stands between the pages of this textbook and in the work of the Red Cross nurses everywhere. No group carries on more gallantly the banner of the spirit of service than do the instructors in Home Hygiene and Care of the Sick; their skill and their devotion give point to the biblical words that are carved along the top of the marble seat that flanks the Delano Memorial:

"Thou shalt not be afraid for the terror by night; nor for the arrow that flieth by day; nor for the pestilence that walketh in darkness; nor for the destruction that wasteth at noonday."

"IF the nurse does her work well she will act as a real interpreter of the worker, his troubles, needs and wishes, to the management, and also as an interpreter to the worker of the difficulties and sometimes almost insuperable problems of the management."—"The Future of Industrial Nursing" by H. E. Collier, *The Nursing Times*, July 27, 1935.

What is Wrong With This Case?

"Wrong Cases" appeared in the May, September, and October magazines. Corrections from readers are usually published two months later. October's corrections will appear in December. The readers' corrections on "Tuberculous Thelma" will appear in January. For some corrections, see page 618 in this number *after* you have listed all the mistakes you can find.

TUBERCULOUS THELMA

ON June 20, 1935, 3:00 p.m., the office nurse in Dr. Hendon's office called the Board of Health Supervisor of Nursing and reported that a nineteen-year-old girl, Thelma Broot, was visiting Dr. Hendon and had described symptoms that were indicative of pulmonary tuberculosis. The patient said she had no money to pay for care, so Dr. Hendon wished to refer the case at once to the tuberculosis clinic at the Board of Health. The women's clinic had been held for that week, so Thelma was instructed by the office nurse to return home, go to bed, and stay there until the Board of Health nurse called. The Board of Health Supervisor took Thelma's name and address and on June 21 a call was made by a staff nurse, Miss Lind, from the tuberculosis department. This history is taken from Miss Lind's record, with developments noted from the records of the visiting nurse association and sanatorium.

June 21, 1935, 11 a.m.: Miss Lind found patient lying in a soiled, disordered bed in a small upstairs bedroom of a six-room house, one north window, no cross draught, no running water or toilet on second floor. Patient's father is dead. Died in the flu epidemic of 1918, but Mrs. Broot reports that he had had a cough for a long time before the epidemic got him. There are two other children, Anna, age 18, and Ross, 25, who is married, has one child and lives in another city. He has not been home in six years. Anna is working in a bakery at night for $14 a week. She sleeps in the room next Thelma's during the day. Mrs. Broot cannot work "on account of my heart." She sleeps on a cot in the living room, and only gets up to her own room on the second floor about twice a week. However, she has had to be up and downstairs more since Thelma's illness. She does not look well.

Until two weeks ago Thelma had a bookkeeping job at $18 a week in a drygoods store. She was fired when she reported off sick for the third time in a month. Mrs. Broot is worried now about getting along on $14 a week instead of $32. She pays $40 a month rent because the house is in a good district and has a little yard. Both girls like to dress well, have permanents, etc. "And my heart medicine is expensive." While the house is rather shabby and out of repair, it has the necessities, and the bathroom on the first floor is clean and in working order.

Thelma's condition: Has felt "weak-like" for several months, had a cough, not much appetite and so tired she could hardly drag herself to work. Patient is thin, flushed, restless, coughs fairly constantly, raising blood-streaked sputum. T. 101 (by mouth), P. 96, R. 22. Not eating well. Sleeps off and on during day and night, but always wakes about 3 a.m. and lies awake until morning. Has a blanket she wraps around her in bed when she sweats. Anna fixes her bed in the mornings and brings her breakfast. She has been going downstairs for her other meals and to the toilet. Is taking cough medicine and a tonic (a patent medicine). Her bowels move regularly.

Miss Lind suggested she send in the visiting nurse to give Thelma bedside care and to teach Mrs. Broot and Anna how to avoid infection (Board of Health staff do not do regular bedside care in this city), and she talked with Mrs. Broot about calling a doctor to see Thelma since she seemed too sick to report at clinic. Mrs. Broot did not feel she could pay for a doctor, but she would like to have Dr. Hendon. After a little further conversation about expenses, Miss Lind found Mrs. Broot had a savings account of $380. She at once urged calling Dr. Hendon. Mrs. Broot asked the nurse to do this.

June 21, noon: Miss Lind called Dr. Hendon, explained the circumstances she had found and described Thelma's condition. Doctor promised to call after lunch and said he would leave orders for V.N.A. nurse.

Miss Lind reported case to V.N.A., which promised to send nurse same afternoon.

4:30 p.m. Dr. Hendon called Board of Health to report his diagnosis of Thelma's condition as pulmonary tuberculosis, moderately far advanced, recommended hospitalization at once at county sanatorium. Was sending in specimen of sputum for examination. Also reported Anna Broot as a contact and a food handler. He had forbidden Anna to return to bakery and ordered Mrs. Broot to report at his office next day for complete examination. Sputum specimens also taken from Anna and Mrs. Broot.

5:00 p.m. V.N.A. nurse reported to Board of Health full general care given to Thelma, and Mrs. Broot and Anna instructed in her care. Anna not to work until doctor gives her release. Anna sent to V.N.A. office for loan of a bedpan, rubber sheet, and to drug store for supply of paper handkerchiefs. Board of Health leaflet of instruction left by nurse.

Application sent by Miss Lind to sanatorium.

June 22: V.N.A. nurse gave care. Mrs. Broot and Anna given complete examinations by Dr. Hendon including X-ray at city dispensary.

June 24: Report of Thelma's sputum positive. Mrs. Broot and Anna negative, and findings of doctor's examination and X-ray negative for both. V.N.A. nurse, bedside care, and continued instruction. Board of Health Supervisor, at Miss Lind's request, writes to Ross Broot of his sister's condition and diagnosis and suggests that he, his wife and baby see their physician at once for a check, also suggests that his mother may need financial help with Thelma's sanatorium expenses.

June 25-29: V.N.A. nurse giving daily care. Reports once a week to Board of Health and keeps in touch with Dr. Hendon. Patient seems slightly improved. Miss Lind has discontinued visits until reply from sanatorium.

Anna complaining. Wants to return to work at bakery. Board of Health forbids this. Anna gives care to her sister during nurse's absence.

June 29: Ross Broot writes to mother, encloses $5.00. Will go to see his doctor soon.

July 5: Sanatorium reports vacancy. Miss Lind visits Thelma, sees that sanatorium equipment is ready, arranges for transferral July 6, city ambulance to station, sanatorium ambulance to meet train, Anna to go with her and return. V.N.A. nurse makes last visit. Dr. Hendon makes last visit and sends report to sanatorium.

July 6: Arrangements carried out. Thelma stands journey well. Anna returns.

July 8: Miss Lind visited Mrs. Broot, instructed her and Anna as to thorough cleaning of house, care of Thelma's bed, etc. Miss Lind visited bakery where Anna works. Made arrangements for Anna to work during daytime in delivery department where wrapped packages only are handled. Anna to return to Dr. Hendon at end of the month for check-up. Mrs. Broot referred by Dr. Hendon to cardiac clinic.

July 9: Letter sent to V.N.A. in —— asking to have a nurse call casually on Ross Broot's family to see if they have gone to doctor. Brief history of case enclosed.

July 10: Report from sanatorium to Board of Health. Thelma losing ground. Miss Lind reported to Dr. Hendon and V.N.A.

July 13: Miss Lind visits the Broots to arrange for Anna and Mrs. Broot to visit Thelma on Sunday, July 14.

July 14: Mrs. Broot and Anna visit Thelma.

July 16: Letter from V.N.A. in —— saying Broots have all gone to family doctor with clean bill of health, but Mrs. Ross Broot is three months pregnant, so V.N.A. will carry and follow family through delivery.

July 19: Sanatorium reports Thelma Broot died rather suddenly following severe hemorrhage. Family has been notified. Miss Lind reports to Dr. Hendon and V.N.A. and calls on family to offer sympathy and help. V.N.A. nurse also stops to see Broots. Case dismissed from V.N.A. files since Miss Lind will visit family occasionally and Mrs. Broot is reporting regularly at cardiac clinic. Is thinking of marrying again!

CLOTHING SUITED TO THE WEATHER

THE temperature of the skin varies on different parts of the body. It is warmest over the trunk, which contains the great organs, and coldest in the extremities. When the body is exposed to cold, the temperature of the surface of the body becomes cooler but the rectal temperature is maintained at normal. Heat is therefore conserved where it is most needed and less goes to those parts of the surface where it is most easily lost.

These facts cannot fail to have a bearing on the choice and adjustment of clothing. Although many conscientious people do harm by overclothing with resulting sweating and possible chilling, more tend to put on too few clothes, especially on undernourished children. Clothing which may be correct in weight and texture for one part of the body may be quite inadequate for another. Since there is a greater relative surface from which heat can be lost in the arms and hands, legs and feet, it is obvious that to keep these parts of the body warm more suitable clothing than is often used should be adopted. If this is done, it will not be necessary for the reserves of the body to come into play to maintain the normal body temperature.

Fortunately the time has long since passed when the weight of clothes and underclothes was set by the calendar. The type and weight of clothing should be adjusted to the day and not the time of year; it should be of such a character that it can also be adjusted to the activity and habits of the individual in the various environments to which he will be exposed.

The problem which has arisen from unemployment is not met by supplying food only, because if the child has not enough clothes to prevent excessive loss of heat much of the energy thus supplied is wasted. Although it may be sufficient to maintain life the quota which should go into growth is wasted.—The Rationale of Clothing of Children by Fritz B. Talbot, M.D., *Child Health Bulletin*, March, 1932.

Nursery School Institute

THE preparation of the nurse in the past has not fitted her particularly for work in the nursery school, however, she can by study and observation improve her technics so that she may more capably give the desired nursery school assistance which lies within her own field of endeavor.

Miss Agnes Samuelson, Superintendent of the State Department of Public Instruction, sponsored the Emergency Education program in Iowa. It was through that department that a special four weeks' institute was planned and conducted at Iowa State College at Ames during August and September, 1935.

The course of instruction provided for twenty hours in various phases of health instruction. Teachers and nurses attended two general health sessions together each week and the nurses had two or more special classes weekly to consider subjects pertinent to their own profession.

The "Manual of Public Health Nursing" published by the National Organization for Public Health Nursing and "The Child from One to Six," Publication No. 30, United States Department of Labor, were suggested as daily references for nurses.

The following classes were conducted by speakers with experience in the special health subject:

1. Coöperation with health and social agencies.
2. What you should know about the Iowa State Department of Health and its programs.
3. Relation to the medical profession and others who care for the sick.
4. Home visits and care of the sick child.
5. Communicable disease control.
6. Infant and preschool service.
7. Emergencies and first aid (including equipment).
8. Vision testing of the preschool child.
9. Morning inspection—disease defects.
10. Childhood tuberculosis.
11. Practical demonstrations of Schick, Dick, Mantoux tests and multiple pressure method of vaccination for smallpox.
12. Personal hygiene.
13. Records and reports.

In addition to the above the following classes were conducted covering: Child psychology, mental hygiene, technic of child guidance, foods, menus and meal planning, administration and organization of nursery schools and parent education.

Fifty-six hours were devoted to observation and practice in the laboratory school and twelve hours for music and discussion on play materials.

Each student spent seven hours each day on class assignments exclusive of library time.

Twenty-five nurses were admitted to the institute and are now being assigned to various schools in the state under the direct supervision of Dr. R. W. Tallman and Isabel Robinson, State Supervisor, Emergency Nursery Schools and Parent Education. The State Director of Public Health Nursing assisted in planning the health program of instruction and is responsible through the State Department of Public Instruction for nursing supervision of those assigned to the nursery school projects.

In an article on "The Preparation of the Nurse for Nursery School" in the September 1935 issue of PUBLIC HEALTH NURSING, the author, Alfhild J. Axelson, R.N., of the Health Division of Teachers College, Columbia University, states that "a prerequisite for the nurse in nursery school work is experience in public health nursing." Only five of the nurses in the class at Iowa State College had previous visiting nurse or school nursing experience. The majority, however, realized the need for such preparation and noted that those who had experience were more alert to the general problems.

Several nurses stated they were interested in taking a course in public health nursing as soon as their finances would permit them to do so.

Special emphasis was placed upon the fact that the institute was not to be considered a public health nursing course, even though certain phases of activities were briefly covered.

The nurses seemed to understand the need for using all available community resources in the promotion of better health conditions for home and school, this, together with a real willingness to pass health problems on to those better prepared to deal constructively with them is the nurse's real safeguard in her assignment as a nursery school nurse.

EDITH S. COUNTRYMAN, R.N.
Director, Public Health Nursing,
Iowa State Department of Health.

Iowa Emergency Education Project—Nursery School Nurses

LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR NOVEMBER, 1935

Nurse-of-the-Month

FLORENCE MEASE

Pennsylvania

I AM BORN

I was born in Pine Grove, Pennsylvania, where I received my preliminary education. After graduating from the Methodist Episcopal Training School for Nurses in Philadelphia, I had considerable experience in private duty and institutional work.

I BECOME A PUBLIC HEALTH NURSE

The public health nursing field offered such wonderful opportunities for teaching, and demonstrating health while working in homes, that I applied for a position with the Visiting Nurse Society of Philadelphia, and became a member of this staff in 1923. Realizing the need for special theory in the public health field, I have taken some work at the Pennsylvania School for Social Work.

The Visiting Nurse Society of Philadelphia, founded in 1886, is the oldest agency in this state for public health nursing, and the second oldest in the country.* The Society is supported by private contributions and by payment for services rendered. Since 1921 it has been a member of the Welfare Federation of Philadelphia. The work of the Society is a generalized program, consisting of a morbidity service which includes communicable disease, a complete maternity service, prenatal, delivery, and postnatal care, and family health supervision. It is offered to everyone in the city of Philadelphia.

I FIND A PLACE TO WORK

The district in which I work is in Germantown, one of the oldest suburbs of Philadelphia, populated originally by Friends or Quakers, many of whom are still living there. A number of their landmarks, while located in what is now the business center, will always be associated with the history-making events of our country. It is this very fact that makes my work interesting. Some visits may be scheduled to the home of folks who have retained, through these troublous times, the earmarks of aristocratic breeding and surroundings, while farther down the street, or even next door, the nurse may be called upon to help an Italian or Negro mother nurse herself or her family back to health.

As a member of a staff in a large city, I can perhaps tell you about my work best by describing what I did one day last month.

I SPEND A TYPICAL DAY

My first call was a new maternity who had been delivered the night before. When I arrived at the home I found a great deal of confusion. Mrs.

*Charleston, S. C., New York City, Buffalo, and Boston claim priority. Historically speaking the matter has not been settled.—*The Editors.*

Murphy was weeping, the children were partly dressed, and Mr. Murphy was standing around, looking very helpless. He explained to me that his sister, who lives in New York, and who had promised to take care of his wife during her postnatal period, had disappointed them at the last minute. I sent Mr. Murphy to the kitchen to heat some water for me, and started him dressing the children. Then I called the Visiting Housekeepers Bureau, and explained the situation to them. They promised to send a housekeeper at once. Mrs. Murphy, who had been a prenatal case of mine, had all the necessary supplies and she was soon made comfortable. Then I demonstrated the care of the baby under the very close supervision of the three little Murphys, who asked many questions. By the time I was ready to leave, the housekeeper arrived. After instructing her in the care of the mother and baby during my absence, I sent Mr. Murphy, who is an automobile mechanic, to his place of employment and left Mrs. Murphy smiling and happy.

My next case was a lady, eighty-two years of age, who has been chronically ill for several years. She lives with her daughter in a clean, comfortable home, but spends most of her time alone, because her son-in-law is ill and in a sanitarium, and the daughter has to work regularly. Mrs. Smith always looks forward to the nurse's visit with a great deal of pleasure.

My last call for the morning was on a convalescent pneumonia patient, who had been quite ill. We were making arrangements to send him to a convalescent home for a few weeks.

I spent the afternoon in our Health Center, where we conduct a well-baby and preschool children's clinic twice a week. This is one of the most interesting features of my work. This service is offered to anyone who can not afford to go to a private physician. It is free, although we accept voluntary contributions. The nurse weighs and measures the babies and has individual conferences with the mothers in order to instruct them in the proper care of their children. There is a physician in attendance who gives each child a complete physical examination. He prescribes for its dietary and other health needs, and provides immunization against diphtheria. The mothers return to clinic by appointment as frequently as the physician thinks it is necessary. The nurse visits in the homes as often as possible to help the mothers in carrying out these instructions and putting them into actual practice. We also have a mental hygiene supervisor, who visits our clinic once a month.

I FIND IT ALL WORTH WHILE

Each day is intensely interesting because of its varied program. There are disappointments, of course, but there are always enough thrills and satisfactions to make up for them. I like public health nursing.

A SALUTE TO THE JANITOR

UPWARD of 1,000 Wisconsin men who are seldom recognized as public health workers are in reality outstanding figures in the promotion of child welfare.

They are the janitors of Wisconsin's 600 graded schools and 400 high schools, entrusted with the administration of preventive measures that involve the physical security of a quarter of a million Wisconsin youngsters.

Their professional equipment consists of a pair of strong arms, an ample supply of chlorine-formaldehyde and sweeping compound, brooms, scrubbing gear, dustcloths, a fatherly heart and a fine sense of responsibility.

Against a host of bacterial enemies they win wars by preventing war. Daily they perform a "clean sweep-down, fore and aft" as thoroughly as it is done in the Navy. They air Wisconsin's schools early in the morning, at noon and after school, and they know the value of sunlight.

Shake hands with the janitor of your children's school. He is an important member of the family's health service.—*Wisconsin State Health Bulletin.*

Dialogue-of-the-Day

ANTHRAX

Public Health Nurse (To herself): This is the first case of anthrax I have seen. I wonder how Mr. Olsen picked it up . . .

Anthrax: I can tell you! He works in a tannery. He handled hides from animals infected with anthrax. Any one working with skins, furs, hair, or wool from infected animals may be infected either through an abrasion in his skin or by mouth. Sheep, goat, cattle, and horse may suffer from anthrax.

Public Health Nurse: How do you act—internally?

Anthrax: My internal form is rather rare. It may give symptoms of pneumonia or dysentery. I am rather serious in this form, especially if I reach the blood stream and start septicemia.

Diagnosis of external or skin anthrax is easier. I start within 4-7 days of infection as a small papule, on the neck, arms, hands, face, or body. I burn and itch and grow quite fast into a vesicle with a clear, serous fluid. After the vesicle ruptures an eschar (with blackish center and scab) about the size of a twenty-five-cent piece is left on a hard and browny area. Sometimes there is pus under the scab and my bacilli can be found at the edges of the scab, cultured and a diagnosis made. There is usually some edema. The carbuncle I make is not very painful. That's one way to distinguish me from an ordinary boil or carbuncle.

Public Health Nurse: Mr. Olsen doesn't seem very sick. Will he be?

Anthrax: That depends. If I can reach a large blood vessel and get into the blood stream I can start a general septicemia. Otherwise, if the doctor treats me and gives—as he usually does—local injections of serum—I do not make the patient feel very sick and I dry up in about three weeks. Sometimes the doctor excises me. Some physicians are using arsenical preparations with good results.

Public Health Nurse: The doctor wants Mr. Olsen to rest in bed.

Anthrax: Yes—that is very important, really, although he doesn't feel sick, and of course he must be isolated with concurrent disinfection of discharges, etc. I have a spore form that is hard to kill; only boiling or burning can do it. There must be thorough terminal disinfection and cleaning.

Public Health Nurse: And now for general prevention. I'll say all the measures I know and you add to them, Anthrax.

(1) Isolation of suspected animals, destruction of those with anthrax, immunization of those exposed

(2) Inspection of all hides. Disinfection of hides of suspected animals

(3) Employment of a physician by all companies handling raw hides, hair or bristles

(4) Proper ventilation and dust removers in wool factories

(5) Careful instruction of employees in sanitary measures, use of disinfectant in washing up, prompt report of any pimples, abrasions of skin, etc.

(6) Control of areas where trade wastes or effluents may be deposited

(7) Investigation of every source of infection.

Anthrax: That just about covers it!

Sources used in preparing this dialogue:

Control of Communicable Diseases—Anthrax. Report of Committee of the American Public Health Association. Public Health Reports, U.S.P.H.S., Vol. 50, No. 32. Aug. 7, 1935.

Report of the Committee on Industrial Anthrax, A.P.H.A. Year Book, 1934-35 (Vol. 25, No. 2), page 73.

Etiology, Pathology, Prevention of Anthrax. C. Y. White, M.D. Bulletin, Department of Public Health, Philadelphia, Pa. March-April, 1934. Also same bulletin: Symptoms, Diagnosis and Treatment of Anthrax. Pascal F. Lucchesi, M.D.

Anthrax of the Skin. Orrin C. Blair, M.D. *American Journal of Nursing*, August, 1931.

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

MISS HAUPT GOING TO THE M.L.I.

Alma C. Haupt, who has been Associate Director of the N.O.P.H.N. since 1929, has resigned to accept the position as Director of the Nursing Bureau of the Metropolitan Life Insurance Company's Welfare Division.

You will regret to hear this announcement, as all of us do who have known Miss Haupt and appreciated the valuable contribution which she has made to the N.O.P.H.N. However, we believe that you will also have a certain feeling of satisfaction in this change, in that you will be glad to have Miss Haupt in this important position with the Metropolitan Life Insurance Company. It will further the coöperation and contacts which public health nurses have with the M.L.I., and we are anticipating that through Miss Haupt's appointment, the public health nursing services throughout the country will continue to have her sound and valued advice and help with many of their problems.

Miss Haupt will remain as Acting Director of the N.O.P.H.N. until the new Director is appointed, and, of course, the other members of the staff upon whom the field agencies rely, are continuing in their present positions, and we hope that there will be no break in the service which the N.O.P.H.N. can provide during this period of change. We do, of course, know that the N.O.P.H.N. has a very loyal group of associates all over the country, and that they will give even more generously of their help at this time. We also appreciate that it is your loyalties which make it possible for the N.O.P.H.N. to function usefully.

And so, while we are exceedingly sorry to have Miss Haupt leave the N.O.P.H.N., we are giving her our very best wishes for success in her new field of work, and are going to continue to count on her active interest and varied contributions to the N.O.P.H.N.

AMELIA GRANT,
President.

J.V.S. APPOINTMENTS

Joint Vocational Service lists the following placements in September, 1935:

Dorothy Rohrer as Supervisor of Nurses, Dallas Public Schools, Dallas, Texas.

Anna J. Haines, R.N., Executive Secretary of the Louisville Health Council, Louisville, Kentucky.

Mary Mulvany as Instructor in Public Health Nursing, Flower Hospital School of Nursing, New York City.

Gertrude Zurrer as Educational Director of the Visiting Nurse Association, Bridgeport, Conn.

Elvira L. Grabow as Director of Health and Welfare, Cook County Hospital, Chicago, Illinois.

Ruth Wekerle, R.N., as staff worker in the Social Service Department of Metropolitan Hospital, New York City.

Mildred Negus as Family Health Counsellor, W. K. Kellogg Foundation, Battle Creek, Michigan.

Margaret J. Lynch and Mrs. Sybil P. Bellos as county nurses for the Westchester County Department of Health, White Plains, N. Y.

Anna Poore as Itinerant Nurse with the American Red Cross, St. Louis, Mo.

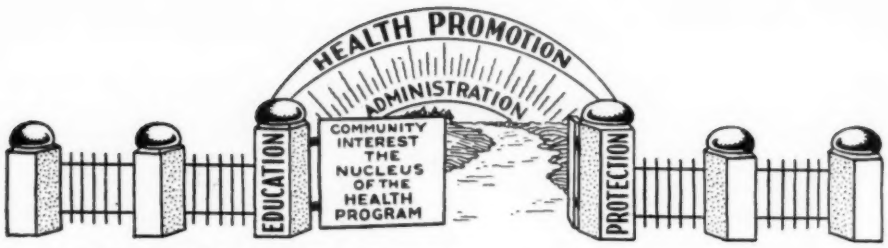
Else Horr as Community Nurse with the Northern Westchester County District Nursing Association, Mt. Kisco, N. Y.

Among the assisted placements made by J.V.S. are the following:

Alma C. Haupt, as Director of the Nursing Bureau, Metropolitan Life Insurance Company, Welfare Division.

Agnes Covalt, as County Nurse, Eddy County Department of Health, Carlsbad, New Mexico.

Maude B. Carson, as Itinerant Nurse with the American Red Cross, San Francisco, California.



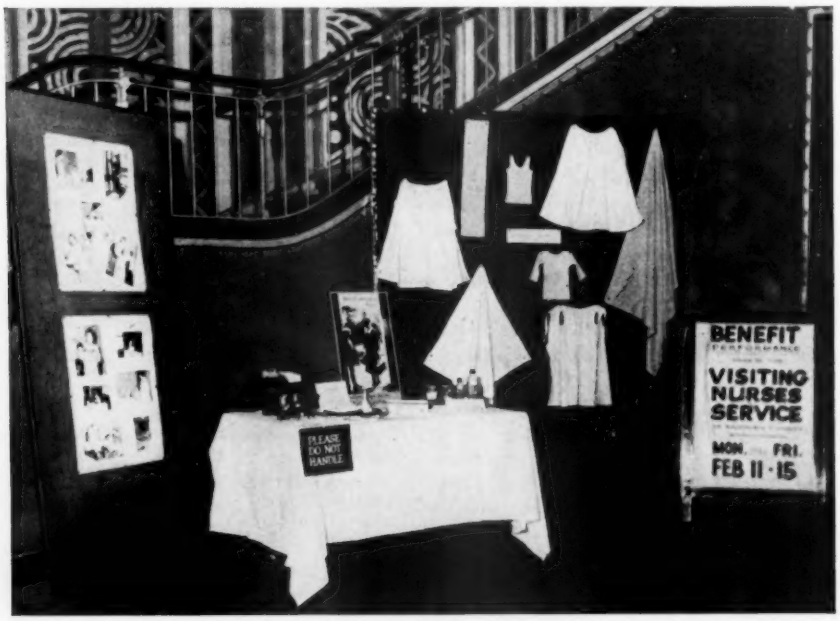
BOARD MEMBERS PAGE *Edited by* KATHARINE B. McKINNEY

THE GUIDE POST

Quite by chance, we suppose, the editors have placed the articles of greatest interest to board and committee members first in this issue. From pages 567 to 619 every article has something of value to us, either as individuals or as board members. Mrs. Harvie's article (page 581) is particularly timely.

GLEANINGS

This exhibit was shown in the Fox Theatre, Hackensack, New Jersey, during a benefit movie showing of the work of the Visiting Nurse Association. The pictures to the left of the table show visiting in the home; the 1935 styles in infant wear are shown at the right. The bag contents and tray are displayed on the table. Elizabeth C. Randall, Director, whose sudden death last month saddened us all, wrote that no nurse was present to answer questions as the small card signs which we see were self-explanatory. One of the observations from the exhibit was that more men seemed to be interested in the baby clothes than women, which may indicate that men are far more interested in health problems than we suspect. To quote Miss Randall: "I recommend a movie benefit as an easy, lucrative way of raising funds."



The stage is set outside as well as in

The Visiting Nurse Association of Wilmington, Delaware, has prepared a "Statement of Principles and Policies" for doctors. This is given to each new doctor coming to town. It describes the type of service rendered under a doctor's orders, its limitations as well as its conveniences, the nurses' hours, fee policy, territory covered and the policies covering the maintenance of well-baby conferences, maternity classes, etc. It winds up with this statement:

"It is the desire of the Visiting Nurse Association to be only of assistance to the physicians. The staff nurses understand that absolutely no suggestions be given as to preference to any physician, and clinics are to be used only when other medical care cannot be secured.

The physicians are asked to make any suggestions at any time to the Director or to the Medical Advisory Committee. Any dissatisfaction of service should be reported to the Director, so that any misunderstanding or error may be immediately corrected to keep up the standards of both the nurse and our organization.

The final analysis of the work of the Visiting Nurse Association is to produce a nursing service that meets the needs of the whole community, and that is a real help to the medical profession."

This statement as a whole was published in the Delaware State Medical Society's *Journal*. It seems like an effective way of reaching the physicians.

BASIC STUDY PROGRAMS

Several visiting nurse association boards have completed the basic study programs (including case studies, community surveys and manuals of information) and have asked for more advanced subjects of study. The following general topics have been suggested by the N.O.P.H.N. (reference reading can be supplied on request).

(1) Problems of unemployment and relief as they affect local public health nursing agencies and programs.

(2) Health Insurance. Experiences abroad and experiments at home.

(3) The Social Security Act. National, state and local plans (while the Act is passed, the appropriations were not passed. It is hoped that Congress will get to these early in its 1936 session).

PUBLIC HEALTH NURSING magazine and *The Survey* both contain articles and editorials on these subjects. The texts of the Social Security Act can be obtained from the Government Printing Office, Washington, D. C.

HALF A CENTURY

A very dressy gold and blue program for the 50th Anniversary of the Buffalo (N. Y.) Visiting Nurse Association has just reached our desk. Besides the anniversary luncheon events, the leaflet contains a very brief summary of: 1885 history, 1935 officers, board, and budget, pictures of some of the officers and of Mrs. Hansen, present director, and her assistant, Mrs. Klein, the staff nurse's pledge of service, the list of the present staff, and two pictures of work, old and new. It is an attractive record of a memorable occasion—a record to be kept down through the years. We congratulate the Buffalo V.N.A. on its first fifty years and the 3,000,000th call made this year!

The Community Chests and Councils, 155 East 44th Street, New York, N. Y., announces the publication of a new poster in black and white entitled "Care for the Sick." It is 10c a copy and has space for a local message. It shows a public health nurse beside the wheel chair of an elderly lady, who is apparently a chronic. The nurse has on her hat and her bag is on the table.

SCHOOL HEALTH

THE PREVENTION OF SCARLET FEVER

As probably all are aware, the severity of scarlet fever has greatly lessened during the past forty years. The death rate now is not ten per cent of what it was then and the number of cases is also somewhat less. Still the disease through its complications not infrequently causes serious trouble and for that reason we use a vaccine to immunize in the same way as we use the diphtheria toxoid to immunize against diphtheria. The scarlet fever toxin is much less poisonous than the diphtheria toxin and therefore we use the unaltered toxin instead of as in diphtheria, an attenuated toxin. If small amounts are given, an immunity for a few weeks may be obtained but larger amounts are necessary if an abiding immunity is wished.

The scarlet fever vaccine is measured in skin test doses. As probably all know, the Dick test is used to decide whether children are immune or not. As in the case of diphtheria, babies born of immune mothers are immune for five or six months. After that time they become susceptible. If therefore we do not want to immunize unnecessarily, we test children with the Dick test; those that show an area of redness of a diameter of 1 centimeter or more are believed to be susceptible while those in whom no reaction occurs or much less than a centimeter are believed to be insusceptible. This is certainly true in the great majority of cases. The vaccine given is usually divided in five doses, namely the first dose of 400 to 600 skin test doses, the second 1000, the third 3000, the fourth 10,000 and the fifth 30,000. With five doses totaling from 30,000 to 100,000 skin test doses an immunity lasting for from one to two years is generally established.

A child with a negative skin test very rarely develops the disease but we have found that among the streptococci causing scarlet fever there are some different types which are not immunized by the ordinary scarlet fever toxin. This is of perhaps more scientific than practical interest since these cases are few.

When a child develops scarlet fever we have as in the case of diphtheria an antitoxin to neutralize the poisons of the streptococci. The only objection to this is that it is apt to cause quite serious serum reactions so that children may be quite miserable for several days. There is also, either in convalescent patients or in animals that have been injected with the scarlet fever toxin, a development in the serum of a blanching substance. This can be used by the physician to detect whether a doubtful case is scarlet fever or not. It is necessary to have a fairly well developed evenly diffused rash and the serum should be injected during the first 24 hours. The dose is given intradermally and 1 cc. is the amount generally selected. Just as in diphtheria the serum of a horse immunized with scarlet fever toxin can be given to prevent contracting the disease. The objection however, is that about forty per cent will develop a rash and fever and as only about two per cent of children in contact with a case of scarlet fever develop the disease, it is doubtful whether it is worth while to give the serum.

With the use of the vaccine to prevent and the antitoxic serum to cure or lessen the severity of the disease, the number of cases and the percentage of deaths from scarlet fever is gradually diminishing.

WILLIAM H. PARK, M.D.
Director of Laboratories, New York City Department of Health.

FEEDING CHILDREN AT SCHOOL

One of the questions particularly pressing within the last few years with which the school nurse is usually asked to assist, is that of providing nourishment for children at school. This may be in the form of a mid-morning or afternoon serving of milk or a regular noonday lunch.

THE SUPPLEMENTARY MILK FEEDING

It has been the custom for a long time in many places for the school itself or interested civic groups to provide milk to undernourished children during the school day, and there is no doubt that the undernourished child has benefited to a great degree. However, many physicians and authorities in the field of nutrition are beginning to question the value of this procedure when carried out indiscriminately.

Once again we turn to the White House Conference reports,* which offer thoughtful guidance on this question. In "The School Health Program" we find the following recommendations:

"A mid-morning or afternoon serving of milk or other food is a common practice and is considered by some authorities essential in a nutrition program. Many physicians, however, believe that it spoils the appetite for a noon meal; and that it lessens parent responsibility since milk at home is often reduced because children get it at school. . . .

Until experimental evidence is available, the following recommendations are made:

1. Before beginning supplementary feeding in any school, the situation should be studied in respect to the economic status, the type of home diets, the time the various meals are served, and the amount and kind of breakfasts eaten by the children.

2. If this survey seems to justify it, an educational program should be tried out before introducing the extra meal. Even if breakfasts are adequate, the children should be taught to eat them at home; if milk or fruit is low, efforts should be made to have them increased in the home diets; and in other ways to get a normal program of living for the children.

3. If the survey seems to indicate the advisability of supplementary feeding, the type of food that will best supplement the home diet should be chosen and the food served at the time the study shows it to be most needed. This may be immediately on arriving at school, at the morning recess, in the mid-afternoon, at the close of the day, or at more than one of these periods.

4. Parents and children should be educated as to the purpose of the lunch, and efforts should be made to insure undiminished home diets.

5. The wisdom of feeding all children or merely the malnourished should be considered carefully. If the latter, a plan should be devised that will make neither the 'fed' nor the 'unfed' groups feel left out.

6. The effect of the lunch on the weights of the children and especially on their appetites at the following meal should be watched, and if the need to do so is indicated, the program should be modified as to time of serving or type of food used."

In discussing this question in another of the White House Conference reports—"Growth and Development of the Child, Part III, Nutrition."—the statement is made: "Because it stays so long in the stomach, milk is of questionable value when fed in the middle of the morning at school to children who have poor appetites."

THE NOONDAY LUNCH

The noonday lunch presents a rather different situation.

"The school should feel obligated to provide a lunch at school whenever the distance is too great for the children to go home at noon or when they would not receive a suitable lunch if they went home."

The following principles, according to the White House Conference, should be observed in organizing the lunch project:

1. It should operate as an integral part of the school health program.

2. Its function should be educational as well as nutritional.

3. The control of the project should be in the hands of the school authorities.

4. Adequate, clean and wholesome food should be provided at a cost within reach of practically all children. Indigent students should be given opportunity to render service in return for their lunch.

*D. Appleton-Century Co., New York, N. Y.

5. The school program should be so arranged that children may eat lunch at a suitable hour, and have sufficient time to do it in a leisurely fashion.

6. Both administrative and educational supervision should be provided in the lunchroom.

7. The principles of food selection and nutrition should be taught in the classroom and be correlated with the lunchroom teaching.

8. This education should be extended to pupils who bring their lunches from home and to the parents through parent-teacher and other group meetings.

A nutrition committee should be appointed to sponsor the project representing the various groups interested in the plan, such as the home economics department, the school physician and school nurse, teachers and parents.

HELPFUL REFERENCES ON THE SCHOOL LUNCH

You Have a Lunch? Why? Lunch Study Report—a study of the lunch, as a medium for putting into practice health principles taught by the school, undertaken by the National Dairy Council with Dr. Lydia J. Roberts, Department of Home Economics, University of Chicago, acting as adviser. Free from the National Dairy Council, 221 North LaSalle Street, Chicago.

What the Teacher May Do to Promote Nutrition—N.H. 62, American Red Cross, Washington, D. C. Free.

The Rural School Lunch—Free from Evaporated Milk Association, Educational Department, 203 North Wabash Avenue, Chicago.

The Lunch Hour at School—Health Education No. 7, Office of Education, Department of Interior, Washington, D. C. Price 5 cents.

The Rural Hot Lunch as a Health and Social Activity—Mary G. McCormick. University of the State of New York Press, Albany. Free to New York State residents; 10 cents to others.

School Lunch Project for Rural Schools—N.H. 501, American Red Cross, Washington, D. C. Free.

School Lunches. With recipes to serve 50 children. Bureau of Home Economics, Washington, D. C. Free.

The School Lunch. Mozelle E. Craddock. College of Industrial Art, State College for Women, Denton, Texas. 12 cents.

Editorial Note: We are indebted to *Echoes*, published by the Division of Public Health Nursing of the Indiana State Board of Health and to the *Red Cross Courier* for some of the material and references.

PITTSBURGH STUDIES WELFARE FOOD SUPPLIES

TEACHERS and pupils in the household-economy department of Pittsburgh's school system, in an attempt to help families on relief to maintain a normal, healthy diet, made an emergency study of the welfare food supplies to determine how these could be used in supplying their full caloric and vitamin content, also eliminating the routine in the necessarily monotonous daily diet.

Demonstrations were held after school hours in which teachers, pupils and women from the neighborhoods participated, which consisted of cooked food for one day's consumption supplemented by two or three other dinners. Mimeographed recipes, with descriptions of processes used were distributed and questions invited, as the size of the groups permitted intimacy. Frequent visits were made to the homes of the audience, who were mainly of foreign extraction, for the purpose of picking up practical suggestions. The food used in the demonstrations was contributed by the teachers.—*School Life*.

EXTENSION OF CONTEST

As announced in this section of the October number, this magazine will offer a full year's subscription to the person submitting the most appropriate drawing for the School Health Section of this magazine. The drawing should be in black-and-white, to run across the head of the page, and should allow for the words SCHOOL HEALTH, which may be incorporated as a part of the design. Instead of closing the contest on November 2d as previously stated, we are extending the "deadline" to December 1st. Come One, Come All with your drawings! This is a good opportunity to put your ideas onto paper. All entries gratefully received, and winning drawing will be published in these pages!

EDITED BY
DOROTHY J. CARTER

PUBLIC HEALTH ADMINISTRATION IN THE UNITED STATES

By Wilson G. Smillie, M.D. The Macmillan Company, New York. $3.50.

Critics to whom he submitted his manuscript told him that his presentation was "too much a matter of fact description of the *status quo* in public health administration." Dr. Smillie replies that "the elimination from the text of theoretical conceptions and illustrative personal experiences or opinions has been carried out with deliberate purpose." This is a substantial apology. Are all apostles? Are all prophets? Dr. Smillie's book is less exciting than a book of prophesy, but its value to the public health worker lies precisely in its conservatism. In compiling and digesting the various practices of public health administration in the United States the author has shown great industry and, in the reviewer's opinion, excellent judgment too.

Those who are interested in enlarging experimentally the field of public health need not expect much help. There is a chapter on nutrition in which it is stated that each health department should have the benefit of the advice of a trained and competent nutritionist. But we are not told what training or experience should be required and when it comes to organization of health departments the nutritionist is practically ignored.

On the other hand we are left in no doubt as to the qualifications, functions and proper remuneration of a public health nurse. And if country commissioners need proof of the number of nurses they should employ and of how much they should be prepared to budget for their salaries, then we shall lay before them with confidence the printed word as it comes directly from the professor at Harvard University.

J. Rosslyn Earp, Dr.P.H.
Santa Fe, N. M.

TUBERCULOSIS—A BOOK FOR THE PATIENT

By Fred G. Holmes, M.D. Appleton-Century Company, New York. $2.00.

Written primarily for the busy physician to give to his patient, this book on tuberculosis is different. The author, looking objectively at tuberculosis, interestingly and convincingly discusses the situation for the benefit of the patient. It is not intended to supplant medical supervision but to inform the patient how to coöperate more effectively with the physician.

This book will be of value to every public health nurse. It will bring her up to date in newer trends in tuberculosis and should vitalize her interest and efforts. The public health nurse often wonders what to tell the patient when difficulties arise and the doctor looks to her for assistance in securing patient and family coöperation. Here she will find an answer.

Dr. Holmes says, "There is no other factor so potent as knowledge in energizing the whole battle front against tuberculosis. Even though the patient whole-heartedly and implicitly trusts his physician and promises a blind obedience to every instruction, it is much less effective than an intelligent coöperation with a full knowledge of the underlying facts."

The three hundred pages or more cover a brief history of tuberculosis—its early symptoms, treatment and cure. Certain phases take on a new meaning as the author discusses the significance of "history" of the patient, his reaction to a diagnosis, and the importance of establishing the right

frame of mind toward treatment at the time the diagnosis is made. Pitfalls to avoid, planning the treatment, family coöperation, the cure and on to the reconstruction period, are points well stressed by Dr. Holmes. He concludes his book with a "friendly chat between physician and patient," answering ethical questions of the patient.

This book on tuberculosis is an excellent reference for all public health nurses and should be made available for student nurses in all our training schools.

JANET A. SCOTT, R.N.
Buffalo, N. Y.

RECENT PUBLICATIONS

THE TWENTY-FIFTH REPORT OF THE HENRY PHIPPS INSTITUTE FOR THE STUDY, TREATMENT AND PREVENTION OF TUBERCULOSIS. Henry Phipps Institute, Philadelphia, Penna.

DYNAMICS OF POPULATION. Frank Lorimer and Frederick Osborn. The Macmillan Company, New York, N. Y. $4.00. An analysis of recent population and eugenic literature.

GOD'S SOLDIER—GENERAL WILLIAM BOOTH. St. John Ervine. Macmillan. $7.50. Thrilling story of the life of the founder of the Salvation Army.

SEDGWICK'S PRINCIPLES OF SANITARY SCIENCE AND PUBLIC HEALTH. Samuel C. Prescott and Murray P. Horwood. Revised edition. Macmillan. $4.25.

TEXTBOOK OF NURSING TECHNIQUE. Irene V. Kelley, R.N. Third edition. W. B. Saunders Company, Philadelphia, Penna. $2.50.

APPLIED BACTERIOLOGY FOR NURSES. Charles F. Bolduan, M.D., and Nils W. Bolduan, M.D. Seventh edition. Saunders. $2.00. Includes immunology.

NATIONAL HEALTH INSURANCE. G. F. McCleary, M.D. H. K. Lewis and Company, London, England. 6 shillings.

HOSPITAL ACCOUNTING AND STATISTICS. American Hospital Association, 18 East Division Street, Chicago, Ill. $1.00. A manual for American hospitals.

NURSING MENTAL DISEASES. Harriet Bailey. Third edition. Macmillan. $2.50.

THE PRINCIPLES AND PRACTICE OF HYGIENE. Dean Franklin Smiley, Adrian Gordon Gould, Elizabeth Melby. Second edition. Macmillan. $2.50.

BACTERIOLOGY FOR NURSES. M. A. Smeeton. Fourth edition. Macmillan. $3.00.

Those who for a number of years have been constantly looking to the East Harlem Nursing and Health Service as an invaluable guide in developing successful methods of health teaching and family health service will be glad to see the first "yearly" report that the Service has published under the title *A Program Report, 1934*. Gradually year by year a more complete and integrated service has been given to the families under their supervision, with the emphasis always on increasing the knowledge and responsibility of the parents for their own health and social planning—or, in other words, on parent education. The report can be obtained for 30 cents from the East Harlem Nursing and Health Service, 454 East 122nd Street, New York, N. Y.

The August 9, 1935, number of *Public Health Reports*, issued weekly by the United States Public Health Service, is a most important one, containing the report of a Committee of the American Public Health Association on the "Control of Communicable Diseases," revised and brought up to date. Obtainable from the Superintendent of Documents, Washington, D. C. 5 cents.

MENTAL HYGIENE

The report of the Committee on Mental Health appointed by the American Medical Association in 1930 is available in pamphlet form from the headquarters of the Association at 535 North Dearborn Street, Chicago. It is divided into the following sections:

I. The Field of Mental Health
II. The Medical Profession and Mental Health
III. Mental Health Administration
IV. The Legal Aspect of Mental Health
V. Coöperation for Mental Health
VI. Summary and Recommendations

Under the auspices of the Illinois Society for Mental Hygiene, a series of broadcasts was given from March 28 to June 27 on the "Mental Hygiene of School Children" by various leaders in this field. Copies of individual addresses are available at 5 cents each from the Society, 203 North Wabash Avenue, Chicago, Illinois. Typical of the talks on the various phases of mental hygiene are the following:

The Need for Mental Hygiene in the Schools

The Mental Health of the Child Who Learns Slowly
A Mental Hygiene Program in the Public Schools

The Social Work Publicity Council, 130 East 22nd Street, New York, has recently published two new bulletins:

A New Slant on the Case Story—What is the difference between a case story and a short story? What do outstanding contemporary literary persons have to say about social work writing in the case story? How can case stories be made more interesting and readable? These and many other questions on writing case stories are answered in this new bulletin. 50 cents.

Social Work at the Microphone—An 18-page bulletin, the first comprehensive discussion of radio as a tool for social work publicity, giving invaluable information on the Five Principles of Broadcasting; Types of Programs — The Straight Talk, Commentators, First Person Stories, Interviews and Forums, Variety Programs, Spot Announcements, Dramatic Sketches; Production—Electrical Transcriptions; Listening and Listening Groups; also a carefully selected bibliography. 40 cents.

To those engaged in public health work throughout the country, the Social Security Act is of the utmost importance. A pamphlet on one phase of the Act—*Grants to States for Maternal and Child Welfare Under the Social Security Act*—may be obtained from the Superintendent of Documents, Washington, D. C. for 10 cents. This covers maternal and child health services, services for crippled children, and child welfare services.

The August number of *Mother & Child,* the official organ of the National Council for Maternity and Child Welfare (England), contains summaries of the papers given at the National Conference on Maternity and Child Welfare held in London in July, which this year was devoted to the welfare of the child from two to five years of age.

CURRENT PERIODICALS

A debate on sterilization: Intelligent Eugenics by Paul Popenoe, and Futile Immorality by John A. Ryan. Forum, July, 1935.

Feeding the child who has eczema. Dennis Kelly, M.D., and Myrtle Meyer Eldred. A doctor discusses the feeding problems and suggests safe menus for the young child whose eczema is caused by food sensitivity. The Parents' Magazine, September, 1935.

Height and weight of children of the depression poor. Health and depression studies No. 2. Carroll E. Palmer, M.D. U. S. Public Health Service Report, August 16, 1935. Showing that it is the children from families whose income has fallen to a low level whose health has been affected.

In spite of politics. Gertrude Springer. Midmonthly Survey, September, 1935.

Public health nursing in the health triangle. Alma C. Haupt, R.N. The Review of Gastroenterology, September, 1935.

Suggestions for students who are preparing their own meals. Helen Knowlton. The Commonhealth-Personal Hygiene Number, April, May, June, 1935. (Massachusetts Department of Public Health, Boston).

Where every child gets dental care. Carroll P. Streeter. The Farmer's Wife, September, 1935.

RECENT PAMPHLETS

Keep Growing—Nevada Nutrition Report 1934-1935. Extension Division, University of Nevada, Reno, Nevada.

Women Who Work in Offices. U. S. Department of Labor, Women's Bureau, Bulletin No. 132. 5 cents from Superintendent of Documents, Washington, D. C.

Health Insurance and the Public Health. Edgar Sydenstricker, Scientific Director, Milbank Memorial Fund. Reprint of address given before Academy of Political Science. Obtainable from Academy, Morningside Heights, New York, N. Y.

Industrial Injuries to Women in 1930 and 1931 Compared with Injuries to Men. U. S. Department of Labor, Women's Bureau, Bulletin No. 129. 10 cents from Superintendent of Documents, Washington, D. C.

The Thirtieth Year in Review. Milbank Memorial Fund Report for the year ended December 31, 1934. 40 Wall Street, New York, N. Y.

On Health's Highway—Progress in Relation to Cancer Control. New York City Cancer Committee, 150 East 83rd Street, New York, N. Y. 50 cents.

Child Welfare in Virginia. Sweet Briar College, Sweet Briar, Virginia.

CORRECTIONS ON CASE OF TUBERCULOUS THELMA

[*Page 602*]

Miss Lind with the help of the other agencies in this case did a good job. There were a few mistakes, which are listed here, and we hope our readers will discover others and send them in for publication in January.

(1) Check should have been made at once on Thelma's fellow workers in the dry goods store.

(2) *June 20:* The Board of Health might have referred this case for bedside care to the V.N.A. the same afternoon, so V.N.A. nurse could have called next morning.

(3) *June 21:* Miss Lind might have given emergency bedside care. Patient sounds pretty uncomfortable and Miss Lind was not sure V.N.A. nurse would call the same day. This would strengthen her position in the home.

(4) Patient might have been moved to a room on sunny side of house, since one bedroom (Mrs. Broot's) was apparently not being used. Patient probably too sick to use yard?

(5) Temperature should have been taken by rectum.

(6) Should not Board of Health have checked on diagnosis of Mr. Broot's death in 1918?

(7) Should not case have been cleared with Social Service Exchange?

(8) Case might have been referred earlier to V.N.A. in city where Ross Broot was living, since a child was involved (not referred until *July 9).*

(9) *July 8:* Some of this instruction might have been given Anna earlier in order that cleaning might have started the day Thelma left for sanatorium. It is a question if Anna could have done *thorough* cleaning alone (mother unable to help). Extra help might have been sent in.

(10) *July 10:* Family should have been warned of Thelma's failing strength.

(11) Instruction in diet for Mrs. Broot and Anna, important in building resistance, not mentioned.

(12) If Mrs. Broot marries again, problem of home conditions and of income would probably be settled. However, with only $14 a week income, a cardiac patient, and an inconvenient $40 a month house, it seems as though provision might have been made to give family further help.

In General: This case presents the familiar problem of divided responsibility between the health department and V.N.A. Even though there was excellent teamwork here, there is evidence of a little confusion as to some responsibilities and valuable time consumed in reporting back and forth. Why did V.N.A. nurse leave Board of Health instruction leaflet? Why did Board of Health nurse not suggest any precautions on first morning's visit? Did Miss Lind explain to Mrs. Broot what V.N.A. visits would cost? Are Board of Health cases all cleared through Social Service Exchange or should V.N.A. have done this?

READER—

Do you want "Wrong Cases" to continue in this magazine? If so, won't you cut out this slip and mail in an envelope to the Editors, or drop a postcard to us, N.O.P.H.N., 50 West 50th Street, New York, N. Y.

Yes, I would like to see more "Wrong Cases" in our magazine. ☐

Have you a preference as to *type* of cases? Please indicate.....

I am a public health nurse doing ..... work.
(Please state kind of work and whether rural or urban. You need not sign your name.)

• Speaking in Washington, D. C., at the Mobilization for Human Needs, Newton D. Baker said:

"As a matter of fact, it has seemed to me, that private philanthropy pioneers. It pioneers new needs, it discovers new failures to integrate in our social and industrial machinery, and as it discovers those, it discovers their incidence to be wider and wider until after awhile suddenly it is discovered to be not merely an opportunity for private philanthropy but a general public obligation, and when the public conscience has reached the place where it accepts that obligation, then the transfer from private to public philanthropy is a normal and easy transfer.

But there will always be the opportunity for pioneering by private agencies, and the great danger, I think, lies in the too early transfer of the private function to the public responsibility. It must not be until there is general acceptance by the public conscience of the fact that this need which has been pioneered and discovered and ministered to by private philanthropy is in fact a part of the general social burden."

• George St. J. Perrott, research associate of the Milbank Memorial Fund and statistician of the U. S. Public Health Service, will be the director of a national survey of chronic illness which is to be undertaken this fall with funds from the Works Progress Administration.

This health inventory is expected to yield information as to the extent to which ailments such as heart disease, rheumatism, diabetes, cancer, and digestive disturbances prevail in the United States, and the effect of such illnesses on economic and social conditions. The present study will later be correlated with data obtained previously by the Public Health Service in an intensive study of the importance and effect of chronic ailments on the capacity of the patient and family to remain self-supporting.

• The Federal Bureau of Investigation of the U. S. Department of Justice now maintains at Washington, D. C., a fingerprint file especially for the use of law-abiding citizens. Thousands of people in all walks of life have contributed their fingerprints to this file. This offer has been made to school groups and already a number of public and high schools have requested blank fingerprint cards for this purpose, including New Jersey, the Dakotas, Florida. Fingerprinting is of potential value to every citizen as a method of identification and protection.

• Alaska has joined the United States in a united campaign against tuberculosis. This disease, among the native Indian and Eskimo population, has the high death rate of 600 deaths per 100,000; for the white population it is comparatively low, averaging about 50 deaths per 100,000.

• From the *Public Health Reports* of the U. S. Public Health Service, we learn that the Board of Health of New York City has amended the section of the Sanitary Code which provided for the annual medical examination of food handlers. This amendment abolished the yearly examination, but prohibited persons affected with a communicable disease from working in a food-handling establishment and prohibited food dealers from employing any such persons. Medical examination of those engaged in the milk industry is still required.

This amendment was made only after the Commissioner of Health, Dr. John L. Rice, had become convinced that the routine medical examination of food handlers and the issuance of medical certificates had proved illogical and ineffective, and after the unqualified endorsement of the step by outstanding public health authorities, whose unanimous opinion was that such examinations were not of sufficient value to warrant the expense incurred.

APPOINTMENTS

(*For other appointments see also page* 609)

Olive M. Whitlock as State Advisory Nurse, Division of Public Health Nursing and Home Hygiene, Oregon State Board of Health.

Leila Given as Professor of Nursing at the South Dakota State College, Brookings, South Dakota.

Blanche Eddy as School and Community Nurse at Downers Grove, Illinois.

Ruth Kooicker as School Nurse in Harvey, Illinois.

Margaret Brinker as part-time School Nurse, Board of Education, Winnetka, Illinois.

Amber Ellis as nurse with the Thornton Township High School and Junior College in Harvey, Illinois.

Mary G. Griffith as College Nurse at the Colorado State College at Fort Collins, Colo.

M. Doris Larson and Kathryn E. Worrell to the staff of the W. K. Kellogg Foundation in Battle Creek, Michigan.

Eleanor Smith as School Nurse, Augusta City Schools, Augusta, Kansas.

Ethel Jacobs as Assistant Director, Bureau of Public Health Nursing, State Department of Commerce and Industry, Indianapolis, Indiana.

Theresa Campbell as a field nursing representative of the National Red Cross in the Midwestern area, October 1st.

Dorothy Swart as School Nurse, Private School, Scarsdale, New York.

Lucy Massey as Assistant Professor in Public Health Nursing, Western Reserve University, Cleveland, Ohio.

Elfleda Sprague as School Nurse in Monterey, California.

• Word is received from the Davenport (Ia.) Visiting Nurse Association of the retirement of Clara L. Craine, Superintendent, and associated with them for 32 years. Miss Craine was a charter member of the N.O.P.H.N. among her numerous other affiliations. Miss Craine is looking forward to a well-deserved rest.

• A demonstration of corrective work being done for crippled children was given at the Institute held by the Michigan S.O.P.H.N. jointly with the Private Duty Section in September. Louise Knapp and Dr. Lillian Smith also spoke and Mrs. Helen D. Moore conducted a Round Table.